




**Professional Profile of the Outreach Worker in Harm Reduction**



To Eva Marree who has joined us on the PrOWfile Project and also a word of recognition to the self-organised groups and peer driven movements who have been working hard and fighting for people's rights, justice and dignity.



“To work as an outreach worker  
you should be a special person,  
with specific emotional and personal skills.”

Outreach Worker



# CONTENTS

## European professional profile of the outreach worker in harm reduction

<b>Endorsements</b>	07
<b>Acknowledgements</b>	11
<b>About the e-book</b>	15
<b>Introduction</b>	17
<b>Chapter 1</b>	21
Professional recognition of the Outreach Worker in Harm Reduction	
<b>Chapter 2</b>	29
Overview of the professionalisation in each country	
<b>Chapter 3</b>	53
Profile construction methodology	
<b>Chapter 4</b>	65
European professional profile of the Outreach Worker in Harm Reduction	
<b>4.1 Principles</b>	65
<b>4.2 Role of organisation</b>	69
<b>4.3 Professional Profile</b>	75
<b>Conclusion</b>	111
<b>Partners</b>	115
<b>Abbreviations</b>	129
<b>Glossary</b>	131



# ENDORSEMENT

---

## **European professional profile of the outreach worker in harm reduction**

Each day in an outreach worker's life is filled with new situations, new people, different from the day before. To be able to handle this one needs to have a repertoire of different approaches, one needs to have knowledge and skills. But the outreach worker often lacks a detailed and clear job description and there are seldom exact procedures for actual situations. Because of the uniqueness of each situation the outreach worker has to handle it when it occurs. The work is often learnt by following more experienced workers and has an aspect of learning by doing. There is a need to become more explicit about what tool kit is necessary to do the various tasks of an outreach worker.

This book gives an answer to many of the questions that might be asked about what an outreach worker actually does, what attitudes he/she should acquire, and it gives a broad overview of the different activities, knowledge, skills and attitudes the professional outreach worker in harm reduction should know of and be aware of. A lot of work lies behind this extensive overview: it is not only about doing outreach, but also describes the importance of being able to form relationships with service users, and with other service providers, in order to support service users and to create opportunities for change.

People will find this E-Book useful when training new outreach workers, and it will help to create debate and reflection for the more experienced workers, thus becoming even better at doing their work.

*Anniken Sand*

Oslo Competence Centre, Norway

# ENDORSEMENT

---

## European professional profile of the outreach worker in harm reduction

Democracy and Human Rights are going through a huge crisis brought on by financial wars in the control of resources. The neoliberal model has generated an enormous abyss between the rich few and the many poor - a system that generates social exclusion and poverty. The market overwhelms the state (that should be producing and administrating laws and ethics), and the community (that should be ensuring identity and social cohesion). Even science and the law seem to exist just to correct some of the excesses of the market.

Socially excluded populations are like the infantry... they go on ahead, searching for new, alternative ways of living, rehearsing with their own lives escape-lines from this decadent system. These excluded populations are very reluctant to accept traditional interventions because most of the time technicians and policy makers are seen as the enemy, they are on the other side of the barricade, they are seen as part of the cause of their problems of poverty and exclusion. Thus, it is not possible to undertake good interventions in this scenario, and against the will of the people involved.

Outreach work in harm reduction has been succeeding where other approaches have failed. Building trust relationships, without moral judgements, centred on real needs of the target population allows the worker to connect in a more profound and realistic way. For these reasons the outreach worker is usually a special person with special abilities.

Therefore, the profile definition of this worker is, for us, a breakthrough of great social value. We hope this acknowledges that these workers are not found by chance, that their skills are recognised and their jobs protected.

We know there are some risks, we know that social control networks will try to use these bridges as a means for disciplinary methods to reach publics that are on the margins, and this will be a constant challenge for both workers and organizations. So, from a pragmatic point of view, we believe this is a great step for the acknowledgment and protection of many workers, and also the recognition of a better approach to less normative contexts.

We, therefore, congratulate everyone involved in this work.

*Rui Coimbra*

CASO - Portuguese Drug Users Organisation



# ENDORSEMENT

---

## European professional profile of the outreach worker in harm reduction

You're reading a very timely book. Not because it's an E-Book, but because it's an important effort to professionalize a new and evolving profession. Harm reduction, in many countries, has only recently become part of official drug policies and is not very securely anchored. The overview of the situation in different countries in chapter 2 shows the fragile position many outreach workers in harm reduction are in: no official training or job recognition and low salaries. A professionalization of the "OWHR" job is needed and fits in perfectly with the European 2020 agenda for new skills and jobs.

The authors have done a remarkable job in developing in this E-Book a European Standard for the OWHR profile. This book reminded me of the term proposed by Gerry Stimson in 1990 of "poly drug worker": he called for a redefinition of the traditional tasks of drug workers to face challenges related to HIV and AIDS in drug users. The described OWHR profile seems to correspond to a "poly drug worker" and even more.


The profession of Outreach Worker in Harm Reduction will surely evolve. Substance use and substance users have a changing profile, harm reduction efforts should continuously adapt to this reality. The many professional and social competencies of outreach workers in harm reduction can and should be used beyond the field of illegal drugs, and surely even beyond the field of drugs. Continuous education of the OWHR should thus remain on the agenda.

Harm reduction should be part of any coherent substance use policy, with (and not replacing) prevention, drug treatment and regulation. Outreach workers have an essential role in reaching those who are in need of harm reduction; their job needs specific and varied competencies.

I would like to thank the authors who have made the effort to better describe this job, set clear objectives for training and thus hopefully help improve quality and recognition of harm reduction.

*Barbara Broers*

Head of the Dependencies Unit, Division for Primary Care, Geneva University Hospitals  
Vice-president of the Swiss Federal Commission for Drug-related Affairs



**LAWMAKERS HAVE BEEN TRYING  
TO STAMP OUT PROSTITUTION FOR CENTURIES.  
AND THEY STILL HAVEN'T  
FIGURED OUT WHY IT KEEPS POPPING UP.**

By a conservative estimate, the average male thinks about sex 24 times a day. Yet the City of San Francisco is convinced that we can end prostitution by arresting prostitutes and the men

who frequent them. An approach that costs us over \$5 million a year and hasn't worked once in the last 200 years. Isn't it time we scrapped these outdated laws? Anyone can see they're impotent.

**THE MARGO ST. JAMES TASK FORCE ON PROSTITUTION.**  
The more you know, the more you'll support decriminalization.

# ACKNOWLEDGEMENTS

## European professional profile of the outreach worker in harm reduction

This E-Book is a product of the project PrOWfile - European Profile of Outreach Workers in Harm Reduction. The project ran between August 2011 and July 2013, with funding from the European Union in the framework of the Lifelong Learning Programme Leonardo da Vinci Partnerships. The European Commission is not responsible for any use that may be made of the information contained therein.

### PrOWfile coordination team - APDES - Portugal:

Joana Marques  
José Queiroz  
Alina Santos  
Sofia Maia

### E-Book editing and review team - APDES - Portugal:

Helena Valente  
Marina Raimundo  
Margarida Martins  
Joana Marques

### Endorsements:

Anniken Sand,  
Oslo Competence Centre, Norway  
Rui Coimbra,  
CASO – Portuguese Drug Users Organisation  
Barbara Broers,  
Head of the Dependencies Unit of Geneva  
University Hospitals and Vice-president of  
the Swiss Federal Commission for Drug-related  
Affairs, Switzerland

### Graphic design:

Moura Pinto  
atelier Mikado

ISBN: 978-989-97276-2-5

Julho 2013

**Authors:**

**APDES - Portugal**

Joana Marques

José Queiroz

Alina Santos

Sofia Maia

**ABD - Spain**

Cristo Cruz

Catarina Alves

Victor Galan

Alejandra Pineda

**A-Clinic - Finland**

Mika Mikkonen

Mija Alho

Greta Jokela

**Akzept - Germany**

Heino Stover

**HESED – Bulgaria**

Rayna Dimitrova

Dragomir Padezhi

Alexander Malinski

Mihail Mihaylov

Peter Tzvetanov

**HRI – United Kingdom**

Maria Phelan

Annie Kuch

**ITACA - Italy**

Maurizio Coletti

Pamela Chiarini

Edoardo Polidori

Claudia Bregli

**Uteseksjonen - Norway**

Lise Kyllingstad

Vigdis Rasten

Kathrine Paulsen

**The Rainbow Foundation-**

**Netherlands**

Eberhard Schatz

Katrin Schiffer

**ROSEA - Sweden**

Eva Marree Smiter

Pye Jakobsson

Carina Edlund

**AFR - France**

Marie Debrus

Thierry Charlois

Valère Rogissart

Special permission was obtained to use a number of photos by Stig Hauger in this E-Book, and to use Posters on Harm Reduction from the Edoardo Polidori Private Collection.



A special thanks for the significant contributions made to some of the E-Book chapters by: Katrin Schiffer, FRG, Netherlands, Pye Jackobsson, ROSEA, Sweden, Catarina Alves, ABD, Spain and Maria Phelan, HRI, United Kingdom.

And further warm thanks to the following valuable contributors:

#### Portugal

Marta Pinto, FPCEUP; Ana Costa, Susana Peixoto, Helena Valente, Cristiana Pires, Daniel Martins, Diana Castro, Isabel Soares, Sandrine Dias, Pedro Machado, Leonor Miranda, Vanessa Branco, Mariana Oliveira, Sérgio Rodrigues, Rui Guedes, Nuno Lourinho, Filipa Soares, Mariana Garcia, APDES; Ricardo Fuertes, Sara Trindade, GAT; João Moreira, R3 – Harm Reduction Network; Cláudia Rodrigues; Domingos Duran, SICAD; Joana Bettencourt – Directorate-General Health – HIV-AIDS National Programme; Alina Santos – RTS – Sex Work Network.

#### France

Olivier André, Médecins du Monde; Anne Guichard, INPES; Emmanuel Augey, Corsica; Emilie Coutret, Techno Plus; José Matos, Médecins du Monde.

#### Bulgaria

Radostina Antonova, HESED; Violeta Bogdanova, National Center for Addictions; Elmira Nesheva, National Center for Addictions; Tsvetelina Oreshkova, Ministry of health; Rayna Dyankova, Initiative for Health Foundation; Emilina Tsenova, Initiative for Health Foundation.

#### Norway

Anniken Sand, Competence Centre, City of Oslo.

And to all the other contributors not here mentioned, our grateful thanks.



# ABOUT THE E-BOOK

---

## **European professional profile of the outreach worker in harm reduction**

This E-Book expects to be an important contribution in the journey towards the full recognition and professionalization of the OWHR.

### **What is this book about?**

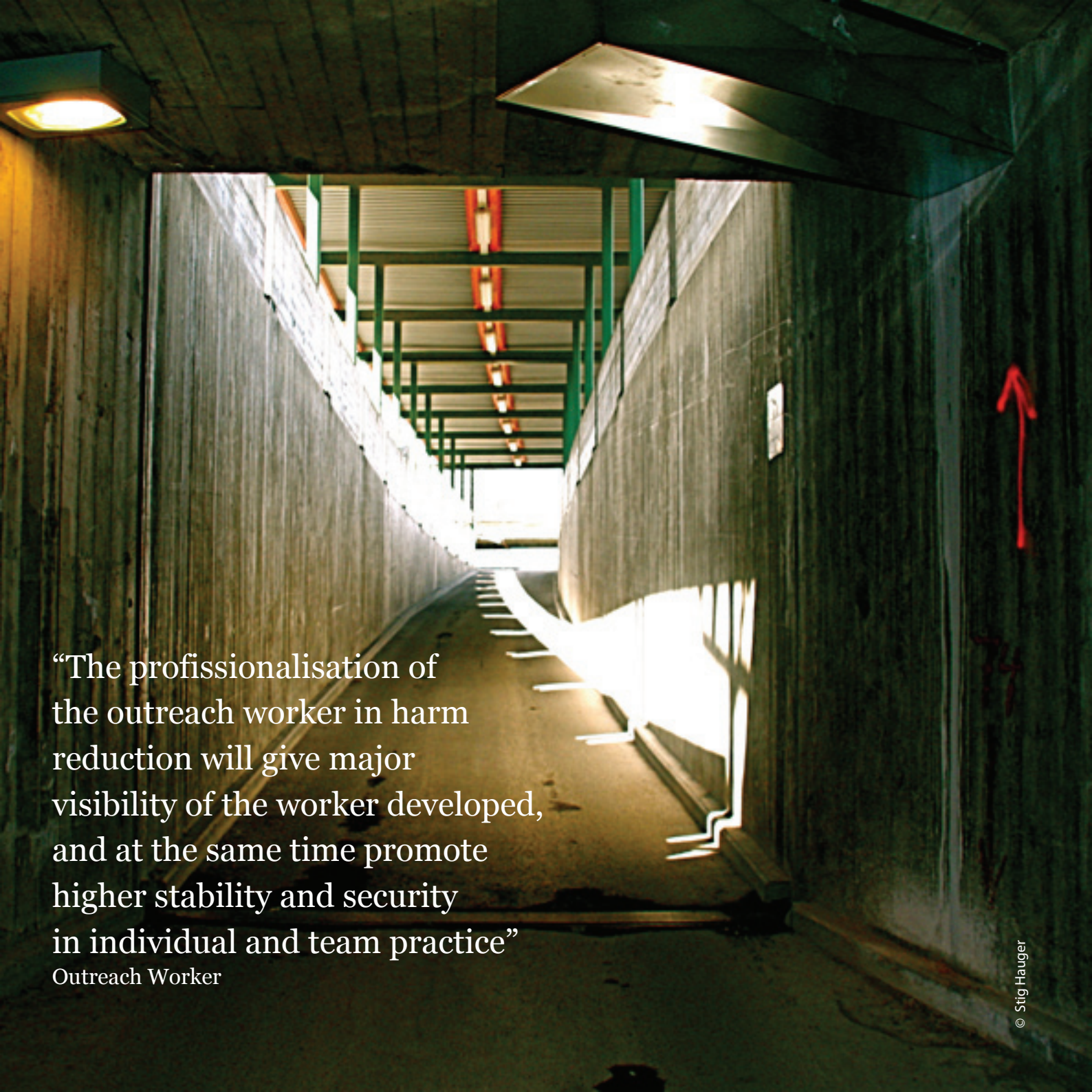
The book outlines the Professional Profile of the Outreach Worker in Harm Reduction, including the activities the OWHR should be able to develop, the skills and attitudes they should possess, as well as important categories of knowledge that should be included in the training curricula of these harm reduction workers. Along with the profile the reader will find several good practice examples from different harm reduction organisations across Europe that will hopefully give inspiration and support to those working in this field.

The manual also presents an overview of the state of the OWHR profession at the moment in 11 European countries.

### **Who is this manual for?**

This manual is targeting not only outreach workers as professionals, peers, students and volunteers, but also decision makers, politicians, trainers and other fundamental stakeholders, who are working or are interested in outreach work in harm reduction settings.





“The professionalisation of  
the outreach worker in harm  
reduction will give major  
visibility of the worker developed,  
and at the same time promote  
higher stability and security  
in individual and team practice”

Outreach Worker



# INTRODUCTION

---

## European professional profile of the outreach worker in harm reduction

More or less ten years ago, a small group of professionals from APDES were confronted with a new arena of action: the streets, the “open scenes” where the drug users spent most of their time... Despite the experts naming these life scenarios “open scenes”, the communities living there were considered as “hidden populations”. And why was that? Because they were rarely in contact with the health and social structures, never having an opportunity to see a doctor or to have a chat with a social worker. These were people never touched by the long arm of the social-sanitary system. Unknown and abandoned to their fate, these were people wandering from street to street. So these professionals were challenged with a new set of obstacles, experiences and ways of approach which were completely new. For the first time in their lives, these “open” settings exposed them to a new way of engaging with the communities, quite distant from the secure base of their desk at the office.

Probably the first question these professionals had was: How to reach these hidden populations? How to draw them out? Gradually, the team started to be confronted with the concept of Outreach.

Working on the frontline, these workers embraced a unique area of activity: the Harm Reduction field. With a pragmatic and non-judgemental attitude, they were centred on the client, trusting in their own principles for action in a humanistic approach. The outreach worker in harm reduction was, at least in Portugal, a new “labour persona” emerging from “nowhere”, a new social actor, which would fill a void left by the traditional professions of the health and social system. The outreach worker performing on the frontline zone extended both the control limits and the boundaries of support.

Usually, a new working environment requires an innovative set of strategies to deal with a new range of challenges. Novelty: that was the key word, a word that raised more questions than answers. Indeed, what was new in the

approach of the outreach worker? What sort of skills were required by this activity? Was this a technical procedure or a broader activity that could be accomplished by other actors like the Peer or the Volunteer? Did we all have the same understanding about this work? And where was the valuable training to sustain and to validate the outreach work?

A question without an answer increases our feeling of anguish and that was the prevalent sentiment amongst our teams. In those days we were unable to find adequate answers amongst other colleagues or even in the research field. There was some research and scattered training guidelines around Europe; but apparently there was never a serious attempt to establish a professional profile on the outreach worker in the harm reduction field. At least, a consistent methodology which could encompass different outreach settings such as party scenes, sex work and prison contexts, as well as the “traditional” drug use framework. Indeed, our contact with countless diverse projects at European level allowed us better access to different experiences, showing us that outreach work in harm reduction was a matter of great breadth both in contexts, and in affected communities.

Finally, we wanted some answers. Good answers. And consequently we challenged ourselves to promoting a project across Europe that could establish a first profile on the outreach worker in harm reduction. We invited friends and institutions, from the North to the South, and from the West to the East of our continent. And they generously accepted. We were eleven partners.

It is our belief that this E-Book can inspire others to carry on this path. We are facing hard times across Europe. Times where the term “civil society” is becoming once again a vague concept on the political vocabulary. Times where other words are following the same destiny: “welfare state”, “universal access to health”, “minorities’ rights”, “human rights”, “citizens’ participation”, and mostly the word “democracy”. Indeed, western society seems to be moving in a dangerous direction, a direction where our destiny is escaping from our hands. And therefore, to write in a cooperative and unified approach, is a way to reclaim a voice. Our voice.

However, when we write these final words, a feeling of discontent comes over us. Were we generous enough with the role of Peers and Volunteers in this E-Book? Did we pay a just tribute to their silent, but persistent work? Have we somehow misunderstood and proposed the assumption that this job could be encased within the space of a fixed and permanent “iron cage”? Slashing, so to speak, the spontaneity and creativity so essential to the effectiveness of the outreach activity. Perhaps with these texts we have contributed to the wrong idea that this job could only be developed by a certain kind of professional (those who possess technical expertise). But if that is the case, if we let ourselves be caught in the trap of over-professionalisation, this is the right moment to say that we are not buying this idea. We do not share the idea that outreach work in harm reduction is the particular possession of a few disciplines or a small handful of professionals. It goes further, it gathers Peers, Volunteers and Professionals. Bringing them together at the same table with a single focus: the people out there living in a vulnerable condition

**José Queiroz**

Executive Director

APDES, Portugal



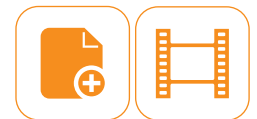


# CHAPTER 1

## European professional profile of the outreach worker in harm reduction

# 1 Importance of the recognition of the outreach worker in harm reduction

Outreach is a client-oriented and community-based harm reduction method which allows health and social services to be delivered to communities and clients in their own settings<sup>1</sup> without the need for them to enter static services. Outreach ensures interventions reach all who need them and is often an entry point into a range of other services. Outreach is widely acknowledged as a key component of harm reduction programmes and best practice when delivering low-threshold services.<sup>2</sup> Available evidence supports the view that outreach, and face-to-face contact between outreach workers and the target group, is associated with reduced risk behaviour and reduced exposure to HIV<sup>3</sup>, thus being strongly recommended by WHO, UNAIDS and UNODC (2012) as a method of service delivery and as an essential component of all HIV prevention and care programmes<sup>4</sup>.



1. Korf, D.J., Riper, H., Freeman, M., Lewis, R., Grant, I., Jacob, I., et al. [1999], Insights: outreach work among drug users in Europe: concepts, practice, and terminology. Lisbon, Portugal: European Monitoring Centre for Drugs and Drug Addiction. Available at: [www.emcdda.europa.eu/html.cfm/index34000EN.html](http://www.emcdda.europa.eu/html.cfm/index34000EN.html)

2. Ibid 1

3. WHO, UNAIDS and UNODC (2004). Policy Brief: Reduction of HIV Transmission through Outreach. Available at: [http://www.unodc.org/documents/hiv/aids/Reduc\\_trans%20outreach\\_eng.pdf](http://www.unodc.org/documents/hiv/aids/Reduc_trans%20outreach_eng.pdf)

4. WHO, UNODC, UNAIDS (2012). Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 Revision. Geneva, Switzerland: World Health Organization. Available at: [http://www.who.int/hiv/pub/idu/targets\\_universal\\_access/en/index.html](http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html)

# What is harm reduction?

Harm Reduction refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs, without necessarily reducing drug consumption<sup>5</sup>.

Harm reduction as an intervention has been endorsed by the WHO, UNODC and UNAIDS. Harm reduction as a basic philosophy lies at the heart of many outreach activities today<sup>6</sup>.

Although traditionally the definition of outreach in harm reduction has focused on drug use contexts, the outreach method can be used in a variety of settings, such as party scenes, drug use settings, sex work and prison contexts, amongst others.

5. Harm Reduction Association. What is harm reduction? A position statement from the International Harm Reduction Association. Available at: [www.ihra.net/files/2010/08/10/Briefing\\_What\\_is\\_HR\\_English.pdf](http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf)

6. Ibid 1

The outreach work has gained relevance in harm reduction settings and has been widely disseminated around the world. Despite its relevancy and widespread dissemination, outreach work in harm reduction still lacks a framework of guidelines and working standards which can be applied at European and national levels. This leads to misinterpretations and significant arbitrariness in the understanding and development of outreach work by those involved in this area, namely organisations and their workers.

EMCDDA states that “given the unique nature of outreach work and the widely divergent state of the art, the most urgent needs of the outreach projects themselves at the present time seem to lie in improvements to the actual practice of outreach work”<sup>7</sup>. It makes a number of recommendations to achieve this, such as formulating working standards and methods, as well as the creation of dedicated training facilities. These observations are reinforced by European Commission Council Recommendations which state that Member States should include outreach work methodologies within their national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods<sup>8</sup>.

The ILO, WHO and UNAIDS (2010)<sup>9</sup>, although focusing on occupational health and safety of health workers, endorse the development and implementation of training programmes namely for frontline workers. The recommended training places a special emphasis on HIV, TB and other infectious diseases, but also reinforces the importance of other related competencies, such as interpersonal skills, techniques to manage stress and burnout, awareness of existing legislation and regulations.

7. EMCDDA Final Report (1999). Outreach work among drug users in Europe: Concepts, practice and terminology. Lisbon, Portugal: EMCDDA. Available at: <http://www.emcdda.europa.eu/html.cfm/index34000EN.html>

8. Cook, C., Bridge, J. and Stimson, G. (2010). The diffusion of harm reduction in Europe and beyond; EMCDDA Ed., 2010, Harm reduction: evidence, impacts and challenges. Lisbon, Portugal: European Monitoring Centre for Drugs and Drug Addiction. Available at: <http://www.emcdda.europa.eu/publications/monographs/harm-reduction>

9. WHO, ILO and UNAIDS (2010). Policy guidelines on improving health worker access to prevention, treatment and care services for HIV and TB. Geneva: World Health Organization. Available at: [http://www.who.int/occupational\\_health/publications/hiv\\_tb\\_guidelines/en/](http://www.who.int/occupational_health/publications/hiv_tb_guidelines/en/)

The absence of a global profile and working standards (competencies and activities), based on consensus, which can be adopted by outreach workers, that is, the job holders themselves, also leaves these workers without qualification guidelines. Working primarily on the basis of their own perspective of outreach work and harm reduction, or based on the organization's own vision, can have strong (and often negative) impacts on the contacts and relationships established with the target groups, and on the efficacy of their work.

The effectiveness of outreach interventions depends greatly on the skills of these outreach workers and the appropriateness and comprehensiveness of the services provided.<sup>10</sup>

Therefore, much should be done to improve the terms of education and employment of outreach workers. Employment conditions for outreach workers are often sub-optimal with low pay, unsocial hours, limited autonomy and limited opportunities for promotion.

Moreover, working conditions are markedly different from those of mainstream jobs: work frequently takes place outside office hours, outside of a secure agency base, sometimes in unsafe environments, and occasionally in semi-illegal contexts<sup>11</sup>. Only limited training facilities with a specific focus on outreach work currently exist in different countries of the EU, leading to a lack of professional accreditation and a coherent job profile.

The definition of a profile presented in Chapter 4 – European professional profile of the outreach worker in harm reduction - has proven that outreach work is a highly skilled profession that should be recognised as such.

---

10. World Health Organization (2004). Policy Brief: Reduction of HIV Transmission Through Outreach, Evidence for action on HIV/AIDS and injecting drug use. Geneva: World Health Organization. Available at: [http://www.unodc.org/documents/hiv/aids/Reduc\\_trans%20outreach\\_eng.pdf](http://www.unodc.org/documents/hiv/aids/Reduc_trans%20outreach_eng.pdf)

11. Ibid 1



L'Association Française pour la Réduction des Risques p...ente



25 & 26 OCTOBRE 2012  
104 RUE D'AUBERVILLIERS  
75019 PARIS



JEUNES  
ANALYSE DE PRODUITS  
ESPACE DE CONSO  
NOUVEAUX OUTILS  
POLITIQUE DES DROGUES  
REGROUPEMENTS  
ÉVALUATION  
FESTIF  
HÔPITAL  
DÉPISTAGE  
DÉP...

# QUATRIÈMES RENCONTRES NATIONALES RÉDUCTION DES RISQUES LIÉS À L'USAGE DE



“The instability, employment precariousness and absence of career prospects are important limitations which creates a high turnover in the area of outreach work, with serious and inevitable consequences to the service users.”

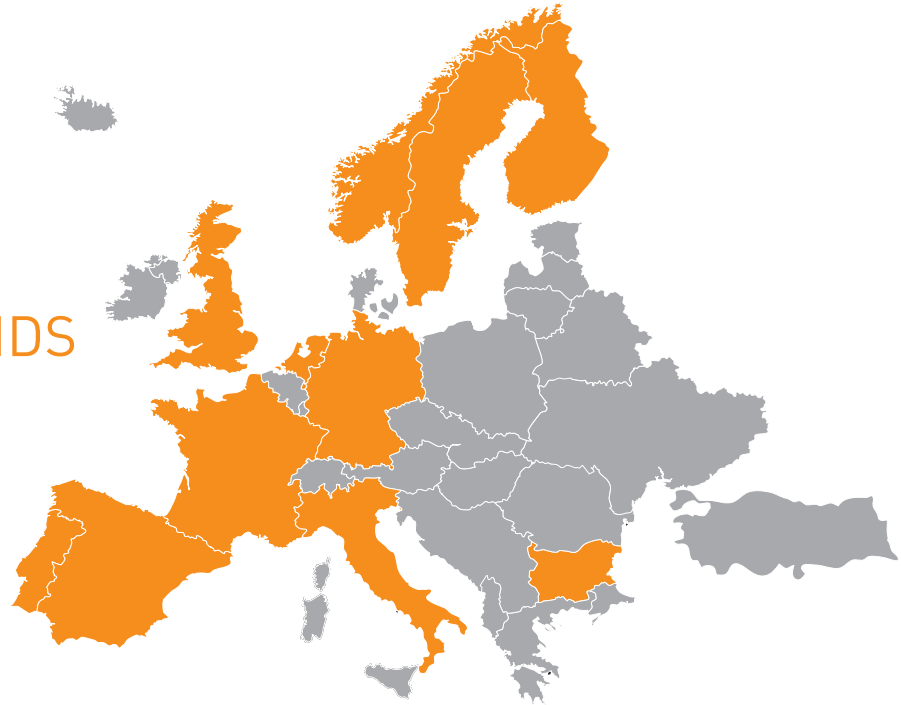
Outreach Project Manager



## CHAPTER 2

### OVERVIEW OF THE PROFESSIONALIZATION IN EACH COUNTRY

- 2.1. PORTUGAL
- 2.2. FINLAND
- 2.3. FRANCE
- 2.4. THE NETHERLANDS
- 2.5. ITALY
- 2.6. NORWAY
- 2.7. SPAIN
- 2.8. SWEDEN
- 2.9. GERMANY
- 2.10. UNITED KINGDOM
- 2.11. BULGARIA





## Recognition of the outreach worker in harm reduction

In Portugal there is no legal or formal framework for the outreach worker profession in harm reduction, although harm reduction is a legislated policy (decree-law 183/2001) since 2001. There are currently no initiatives towards recognizing this profession. A [procedures manual](#), for the Syringes Exchange Programme, edited by the HIV Portuguese National Coordination, has a brief note (produced by the National Harm Reduction Network that integrates 25 HR teams) on the profile of the “outreacher”. This document points to the personal, technical and political competencies of the OWHR. Despite the fact that this network has debated these standards there is no common informal regulation applied by the teams that participate on this platform. Furthermore, there is no agreement regarding the competencies, profile or training guidelines for the performance of harm reduction activities at national level.

## Outreach work in harm reduction and the workers

Harm reduction work is done mainly by Non Profit Organizations and is funded by governmental, European and international public or charitable funding. We estimate there are around 60 teams, 200 professionals and 240 volunteers working in Harm Reduction in Portugal. The majority of these professionals are social workers, psychologists, nurses, psychosocial professionals, amongst others. Most have a bachelor’s degree but some only have a secondary education. Usually harm reduction work is done by professionals, doing a full-time (40h/week) or part-time (20h/week) job. Although it social commitment, this profession is characterized by low salaries, job instability, absence of career prospects and is usually established by the period of funding. It is also common to find a lot of volunteer and unpaid interim work in harm reduction outreach. [Peer work](#) is still rare, but slowly increasing among outreach teams.

The main outreach settings are drug use, sex work and party scenes (other populations such as prisoners are not widely approached). The harm



reduction outreach intervention is defined by each organization, according to their own principles and views on the phenomenon and harm reduction itself.

## Harm Reduction Training

Training in the field of harm reduction is mainly done by each organization (on the job training). There are no training guidelines or manuals as any training programmes, content or principles to perform harm reduction work. Harm reduction is rarely included as a subject in Health degrees - nursing, medicine, education - despite some students undertaking their internship in harm reduction services.

The University of Porto is the only University that provides a curricula discipline on this theme, as part of their Psychology Degree.

Sporadically, other training courses in harm reduction are provided, for example by NGOs, Universities and the Governmental Institute for Drug Addictions. However, none of these courses has led to the professional qualification of a HR worker and there are no technical or professional training courses, Level IV, V or VI, incorporating harm reduction settings. There are other training, technical and academic degrees linked to this field, such as those related to drug use, community intervention and other outreach subjects.

**In 2009, APDES organized its first training on Harm Reduction: « Harm Reduction associated with Drug Use and Sex Work : Concepts and Practices. » with a duration of 84 hours. Since then APDES has organized 4 other smaller trainings sessions.**

## Recognition of the Harm Reduction Professional

In Finland there are no professional recognitions or degrees for the outreach or harm reduction workers, though people working for the prison services can complete a harm reduction course of 4 academic credits. The results of the research and practise in Finland show that health counselling/needle exchange services in 29 cities, and the harm reduction policy implemented in them, have become a significant part of the everyday lives of many drug users. At the services, the users receive help and support that is not available elsewhere in society. The harm reduction policy implemented in Finland is therefore a positive example of significantly increasing the social confidence of a population group that is socially quite excluded, and often even "demonized", by working methods that listen to them and activate them, even without professional/national recognition or a degree.

## Outreach work in harm reduction and the workers

The Harm Reduction policy has been carried out in Finnish health counselling/needle exchange services for fifteen years. The activity has become a central part of Finnish social and health services, but simultaneously various stereotypical beliefs, e.g. of approving of drug use and maintaining the drug problem, are still related to the activity. The harm reduction work and outreach work is mainly done by NGOs and is funded by the government, the National Lottery Association and the Social and Welfare Ministry. There are around 200 people working in the field of harm reduction drug use and sex work, coming from various backgrounds (nurses, social workers, pre-nurses, youth workers, doctors, peers, etc). There is only one yearly national seminar, which brings the professionals together, with the peer workers, to reflect on and develop harm reduction work.



## Harm Reduction Training

As previously mentioned, only people working for the prison services can complete a health course in harm reduction of 4 academic credits. The staff training is organized at the Prison Personnel Training Centre and Laurea University of Applied Sciences. Training for prisoner drug users is organized by health and rehabilitation personnel in each prison, in cooperation with local Health Education Centres for Intravenous drug users. The goal is to create harm reduction recommendations and a model for all prisons with the help of: accredited operations model/training programmes for prison staff and peers to organize harm reduction oriented health education for drug users based on peer influence. Also, peer educators have access to a manual for running harm reduction counselling and guidance programmes that lead drug users to care services and professionals.

**University of Applied Sciences (HUMAK) organises the first outreach youth model training in Finland (2013), with a scope of 10 academic credits. It will be an educational update for the already graduated.**

In the capital area of Finland A-Clinic Foundations peer work is involved in a joint venture with the Helsinki Department of Social Services and several other agencies utilising peer work, in line with the new guidelines set by the Finnish National Institute for Health and Welfare for mental health and substance abuse work and the Social and Welfare Ministry. The group is providing training forums, in which professional social workers can work side by side with the peer workers to increase mutual understanding between active or recovering drug users and professionals, thus ultimately facilitating service-provision.

## Recognition of the outreach worker in harm reduction

Harm reduction policies have been recognized since 2005 in the public health law.

Since then, a lot of harm reduction services (NGOs) have integrated the healthcare system (to get sustainable grants).

Currently, there are 3 types of status of harm reduction organisations:

- Independent non profit organisations: numbers not known
- Non profit organisations integrated in the healthcare system providing harm reduction services (excluding treatment): more than 130 services
- Non profit organisations or hospital services integrated in the healthcare system providing harm reduction services (in theory, but only a few really do) and treatment: more than 260 services

Nevertheless, the harm reduction technician is not an officially recognized profession.

There have been initiatives towards the recognition of this profession, but they have not worked because in France there is a rigid framework regarding the work field (salary grid, collective conventions per economic field, etc.) and the initiatives face problems with workers Unions, etc.

## Outreach work in harm reduction and the workers

Concerning the competencies profile, each organisation providing harm reduction services has its own role, practice, profiles, tools, etc. But the core militant associations agree on competencies like non-judgment, relational capacity, trusting relationship with clients, no systematic objective of pushing clients to the “normal” social care system, etc.

Performing this work we have professionalised peers, social workers, educators, nurses, etc.

For the organisations integrated in the healthcare system, the professionalised peers are obliged to study and get a diploma or to officially validate their skills.



Some of them start earning less when their organisation integrates the health care system, because they incorporate the official salary grid at a low level. But they have sustainable salaries. For the other technicians (nurses, educators, social workers, etc.) it is quite heterogeneous (depending on the work and the related salary grid). In fact, they earn at the minimum 1.000€ (plus bonus because they work at night, on weekends, etc.) An educator starts at 1.350€.

## Harm Reduction Training

In the “initial training” (universities, schools, etc.), harm reduction is not included in the study content for nursing, medicine, education, etc. But some of the students undertake their internship in harm reduction services.

- In a post-academic diploma on addiction, sometimes harm reduction is included.
- In lifelong learning training for workers, the major French federations (Addiction Federation or Association Française pour la

Réduction des Risques - AFR) propose training sessions contemplating harm reduction, safer injection, safer nightlife, needle exchanges, harm reduction tools, substances, infectious diseases, etc.

These courses are not certified by any education authority and they do not lead to a professional qualification.

The universities and the National qualification body are the organisations responsible for certifying professional qualifications. There is no university diploma on Harm Reduction but it could be possible if a professor decides to create one.

The challenge now is to integrate harm reduction in the education field (initial training to learn a job).

**The National Conservatory of Arts and Crafts and AIDES, a French NGO involved in HIV, hepatitis and harm reduction, has developed a new qualification in community health.**



## 2.4. THE NETHERLANDS

by The Rainbow Group

### Recognition of the outreach worker in harm reduction

In the Netherlands no formal or specific professional category exists for outreach or harm reduction workers.

Outreach work is mostly seen as a methodology and work area within social work, not necessarily connected to harm reduction. Outreach work is defined broadly in the Netherlands and is used for various target groups and in different settings. It provides support to marginalised and vulnerable groups 'outside the office'.

Harm reduction has been integrated in the Dutch Drug Policy and Care System for decades and there is an overall consensus that Harm Reduction has proved to work in the Netherlands, especially in regard to hard drugs.

**There are numerous methadone, needle exchange and heroin programmes and a total of 35 drug consumption rooms all over the Netherlands.**

Harm Reduction is professionalised to a high extent by getting a regular part of the work with drug users. Municipal health services and major service providers apply harm reduction services as part of their integrated approach, which links social, medical and drug free treatment. Therefore social workers or medical staff in this field do not necessarily describe themselves as harm reduction workers, but as workers in the health care system.

### Outreach work in harm reduction and the workers

Harm Reduction is an integral part of the work with drug users and is mainly carried out by private service providers as well as Municipal Health Services.

**Methadone and Heroin programmes are run mainly by Municipal Health Services, but there also numerous GPs which give methadone treatment to individual drug users.**



There are a number of low-threshold service providers providing services to vulnerable groups, including drug users, homeless people and people with psychiatric disorders. These organisations provide basic services, such as day and night shelters, showers, clothing and food, as well as counselling. A limited number of organisations maintain drug consumption rooms.

The professional background of the workers in harm reduction settings varies: social workers, nurses, psychologists, sociologists. Many workers have a totally different professional background or started as a volunteer. These workers are often stimulated to follow additional education and training to become a certificate social worker. The salaries of those working in harm reduction settings are low and there are limited promotion opportunities.

The involvement of peers in harm reduction settings became common and there are a number of organisations in the Netherlands, which work with peers.

Mostly these peers are employed as part of a re-integration project, which means that they can earn a small additional amount on top of their social benefits.

## Harm Reduction Training

The only educational institutes which include outreach work and harm reduction in some form are the Social Academies, which hand out certificates for social workers (level 6/level 7).

There is no curricula for harm reduction workers in outreach settings, but the Social Academy in Amsterdam has just recently established a minor on outreach work, in which upcoming social workers are being educated in the basic principles of outreach work.

Some service providers also organise and facilitate regular in-service training for their workers, such as anti-aggression training and overdose training. In Amsterdam a number of NGOs combined forces and established a volunteers academy, which provides training and support for volunteers and peers, who are active in the care and help system in Amsterdam.



## Recognition of the outreach worker in harm reduction

In Italy there is no real recognition for the outreach worker profession in harm reduction, even though in 2000 the National Guidelines on Harm Reduction was produced by the Ministry of Health and Ministry of Welfare.

In 2012 the Italian Anti-Drugs Policies Department issued a document which limited Harm Reduction to the reduction of diseases related to drugs addiction.

Finally, there is no national official document that governs the training, expertise and professional profile of the outreach worker in harm reduction.

## Outreach work in harm reduction and the workers

Harm reduction interventions are organized autonomously by Regions: some Italian regions delegate this task to NGOs, others choose to entrust interventions to National Health Care Services.

The main activities of harm reduction relate to party scenes, but in some large cities there are also projects working with heroin and cocaine intravenous users, socially marginalized people.

In harm reduction services we can find professionals like medical doctors, nurses, psychologists and social workers; we can frequently find volunteers but rarely peer educators.



## Harm Reduction Training

There is no national training for outreach workers in harm reduction, so some regions have independently organized University and Masters Courses.

In this regard, the Emilia Romagna Region has had for several years a University Course of Higher Education entitled “Proximity interventions: between prevention and harm reduction” with five teaching areas (Use and abuse of alcohol, Related conditions, Toxicology and Pharmacology of substances, Epidemiology and consumer styles, The report help) divided into 78 hours of lectures and 78 hours of alternative education (training course, field training, ...).

## 2.6. NORWAY

by UTESEKSJONEN

### Recognition of the outreach worker in harm reduction

Harm Reduction Professionals are socially recognised in Norway, especially in Oslo, our capital. This is where we have a lot of harm reduction work, and many people have been employed for several years in the harm reduction sector.

The Norwegian Directorate of Health has presented guidelines for substitution treatment for drug users, and both public organisations and NGOs receive public support to do this harm reduction work.

Harm reduction work in Norway is run by public organisations and NGOs. Social workers, nurses, medical doctors, priests and psychologists perform the work, as well as non-professionals. There are full-time workers and part-time workers, and the level of salaries is acceptable.

### Outreach work in harm reduction and the workers

Harm reduction work has been carried out for several years in Norway. 15 years ago the substitution treatment was established for HIV-positive heroin users, to make them more available for HIV-treatment.

Soon methadone was also given to heroin users suffering from a somatic disease.

In the nineties a feasibility study was conducted in Oslo, consisting of 50 heroin users. Methadone was tried out as a substitution treatment on heroin users that had been addicted for more than ten years.

The feasibility study resulted in the common use of substitution treatment in the country. The main objective for this treatment was to prevent overdoses.

Harm reduction work is aimed towards drug users and sex workers. For several years the Pro-centre in Oslo has been handing out condoms to sex workers. They also offer shelter and field nursing including gynaecological help.



In most cities in Norway there is field nursing, offering clean needles and wound treatment for drug users. In Oslo we have an injection room and also a “Street hospital” run by the Salvation Army, especially for drug users.

### **Harm Reduction Training**

There is no formal or organised training or education for harm reduction workers.

In the different education systems for social workers, nurses and psychologists, there is also little training on harm reduction.

Most of the training is given in the different working sites where harm reduction is carried out, and different courses are given as an additional training to people that work in harm reduction.

## **Recognition of the outreach worker in harm reduction**

There is no legal or formal framework for HR by the central Government, although there is social recognition in some regions and provinces.

There are initiatives towards the recognition of the profession but these have been put on hold due to the economical crisis, which prioritizes other issues. As for the description of the different jobs in HR, there are short manuals developed by NGOs, professional groups or local administration in some regions, but there is no agreement regarding the competencies, profile or training of the professionals at a National level.

## **Outreach work in harm reduction and the workers**

There are federations in each region that try to make agreements in relation to guidelines in HR work. In general, all the associations work more or less in the same way.

The funding for HR projects comes from the National Government, Regions and local Government. This has a strong implication in the continuity of the projects: funding can change depending on the economic situation but usually it is more or less stable, especially in the drug use contexts.

The main outreach settings are drug use, party scenes, sex work and prisons. The professionals are mainly social educators, social workers, nurses, psychologists, peers and volunteers who work in HR centers, mobile units and street outreach approach teams. In these teams, professionals rotate a lot because of the low salaries and the lack of recognition in comparison to other fields.



## Harm Reduction Training

The training in HR is done by both NGOs and local Government, depending on the region of the country.

There are no formal training guidelines or any HR degree but, on the other hand, in different Universities of Spain there are Masters or specific workshops in a degree (for example in degrees such as social work or psychology).

The majority of training comes from the NGOs working in the field.





## 2.8. SWEDEN

By Rose Alliance

### **Recognition of the outreach worker in harm reduction**

In Sweden there is no legal or formal framework for an outreach worker professional with a harm reduction focus. Even though the Board of Health and Welfare supports harm reduction initiatives it is still highly controversial as a method and ideology. Social workers and health care providers are still taught a zero-tolerance model in school which does not encourage a harm reduction approach, both when it comes to drug use and sex work. Furthermore, many professionals do not have a clear idea of what harm reduction is about. Individuals working within the health and welfare system that dare to acknowledge harm reduction as a method to ensure health and rights might be questioned within the state system. A social worker from the third biggest city in Sweden gave out condoms to clients of sex workers, seven in total, and this resulted in nearly 30 news articles. Needle exchange is a constant debate as it is seen to encourage an unwanted, and illegal, activity and substitution programmes are implemented with strict regulations.

### **Outreach work in harm reduction and the workers**

Outreach work with a focus on harm reduction is, apart from the south of Sweden, mainly done by groups representing target groups of harm reduction initiatives.

For a long time the Swedish Drug Users Union was running the only, informal, needle exchange programme in Stockholm. Since 2013 there has been needle exchange in Stockholm, but with age restrictions, and on a trial period basis subjected to evaluation before it became a permanent part of the health care system. Likewise Rose Alliance, the Swedish sex worker organisation, is the only one trying to distribute condoms in the street working areas in Stockholm. As harm reduction services are so controversial, rights-based groups representing target populations have to become the service providers as well as the main advocates for harm reduction initiatives. In the south of Sweden the political climate has, in periods, been better and more favourable towards harm reduction.



There are two needle exchanges that have been open since 1986 even though the official legal framework only came into place in 2006. Harm reduction is also part of outreach work directed at sex workers. One of the areas where outreach is best implemented in most parts of Sweden, even though not with a clear harm reduction focus, is services to homeless people.

## Harm Reduction Training

In the south of Sweden most harm reduction professionals will be trained health care professionals or social workers, whilst in the rest of Sweden it is very much about “learning by doing”. People from the target groups will be using their own skillset trying to provide services to peers. Peer work is effective and empowering but when there is no clear financial support from the state, as well as political support, it becomes very fragile and potentially high-risk as it depends on volunteers and organisations consenting to potentially breaking the law and putting at risk future funding. The main schools of social work do not really mention harm reduction, and the schools for health care professionals will cover it on occasion, depending on the tutor, but not as a subject in the curricula. Even so, most health care providers will be positive towards ideas on harm reduction, specially as a tool for HIV-prevention.

## Recognition of the outreach worker in harm reduction

In Germany no legal or formal framework exists for the outreach worker profession in harm reduction. Harm reduction is one of the four pillars of the official drug policy (besides prevention, treatment and repression). At the moment no initiatives towards the recognition of this profession can be identified. Outreach work (here streetwork) is being seen as a critical part of harm reduction to reach the hard-to-reach group. There are some publications by the Deutsche Aidshilfe and Akzept which aim to manualise the outreach work and substantially contribute to a “profile” of outreach work.

There is no overarching description of outreach work within harm reduction work.

Parts of OWHR have been described very well (e.g. work in (mobile) consumption rooms, (mobile) needle exchange programmes, working with drug using sex workers). For these parts even guidelines and standards do exist. However, other parts of OWHR have not been described or standardized as yet.

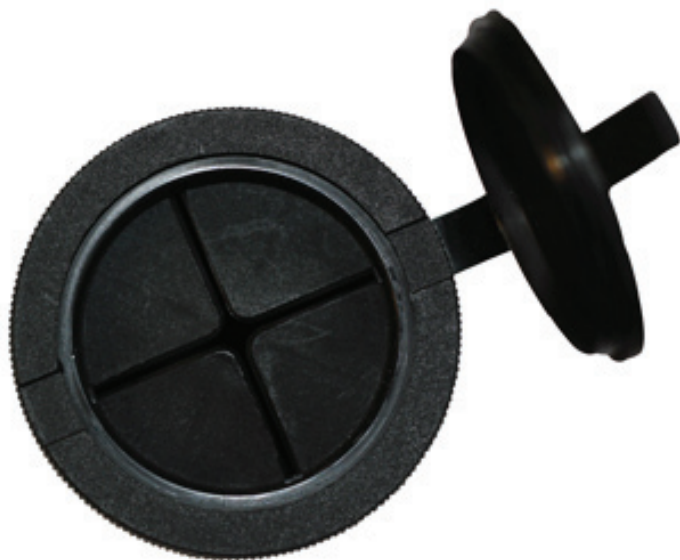
## Outreach work in harm reduction and the workers

Harm reduction work is almost completely done by Non Profit Organisations and is funded by municipal, state or – if it is a pilot project – by federal governmental funds and to a lesser extent by European and international public or charitable funds. There are approx. 200-300 OWHR teams working throughout Germany. The main outreach settings are drug use, sex work and party scenes. Partly OWHR is covered by teams focusing on homeless juveniles and/or migrants. Only Deutsche Aidshilfe is approaching prisoners with regard to HR. The harm reduction outreach services are partly defined as good practice by two umbrella organisations (Deutsche Aidshilfe, Akzept). Furthermore, each organisation will apply its own principles and practical work procedures.

**JES groups exist all over Germany and are working on a peer basis.**



OWHR is mainly carried out by social workers, social pedagogues, nurses. Most of them have a bachelor degree but some also have a Masters degree. Their working hours depends on the individual circumstances of the service providers (a few hours to 40h/wk). Similarly to other social professions, social workers receive low salaries, and are usually not in a stable working structure. Students, volunteers and unpaid interim workers are also often employed in harm reduction outreach work. Peer work is done by JES, “Junkies, Ex-User and Substitution Patients”.



## Harm Reduction Training

The Deutsche Aidshilfe and Akzept both offer training seminars, vocational training and/or targeted conferences to raise crucial points of harm reduction work. Additionally, on the job training is done by various service providers and is adjusted to the specific needs of the community and target group.

Akzept and other German organisations developed some guidelines on how to raise awareness for Hepatitis C and for harm reduction in prisons (both handbooks are available on a national scale and have been partly translated into other languages). However, overarching training guidelines or principles on performing harm reduction work do not exist. **The Institute for Social and Cultural Work (Nurnberg) did a 2 year course** on acceptance-oriented drug work (harm reduction). All in all, over a period of approx. 20 years, some 100 people took this course. Apart from this, training courses in harm reduction provided by various organisations, have been sporadic. However, none of these courses led to a professional qualification of the HR worker.

## Recognition of the outreach worker in harm reduction

There is no formal higher educational recognition of outreach work (i.e. you do not need a university level degree to perform this task). Further educational qualifications exist – through colleges or further educational establishments or continued professional development schemes (CPD). Often outreach work is seen as an important part of a harm reduction programme but is viewed as a ‘stepping stone’ into the area of work due to the poor pay and limited career progression. In fact many outreach workers are volunteers looking to gain experience or skills in order to obtain paid employment. Many of these schemes are free of charge and can be undertaken while at work.

Standards have been set for good quality outreach work through National Treatment Agency (NTA) documents and [National Institute for Health and Care Excellence](#) - NICE guidance.

## Outreach work in harm reduction and the workers

Outreach work is mainly done by NGOs, Primary Care Trusts (PCTs), statutory bodies, companies and peer workers. Usually funded through statutory funding and some charitable trusts. It is impossible to quantify how many outreach workers exist in the UK as many are volunteers and there is no central registry.

There are over 100 harm reduction services in England alone and many have an outreach component to the service.

The main outreach settings are drug use, migrants, party scenes and sex work. The principles and philosophy of the intervention is defined by the organisation and also the funder.

There is a large variety in the type of professionals who undertake this work: social workers, nurses, peer workers, health care assistants and counsellors. Many workers are volunteers and looking to gain skills and experience in order to gain paid employment.



a few lines of

information on  
information on  
information on

## Harm Reduction Training

There is no nationally recognized training in harm reduction (i.e. you do not have to have a certain qualification to perform harm reduction outreach). However a number of training modules are available through non-profit organisations and statutory groups. The National Treatment Agency - **NTA** have produced guidelines on this subject. Other non-profit organisations offer training such as **HIT**. The National Health Service - **NHS** also offers a range of training depending on the region. Most training is offered 'in house' and is subject to the requirements of the organisation that is delivering the service.

aine?



## Recognition of the outreach worker in harm reduction

In Bulgaria the national policy on harm reduction is focused mainly on drug use and is regulated by the Ministry of Health, starting in 2000 with Ordinance № 30/20.12.2000 which refers to the order of participation in pre-treatment and rehabilitation programmes for people addicted or misusing drug substances. In 2011 the Ministry of Health adopted a new Ordinance № 7/07.09.2011, on the conditions and order for the implementation of programmes for harm reduction in the use of drug substances. Certification and control over the implementation of harm reduction programmes and professionals is done by the **National Center for Addictions** (NCA).

In the National classification of professions and positions in Bulgaria, as part of the class ‘Applied specialists of social work’, the profession ‘Assistant, Work with addictions’ is included under code Nr. 34123015.

## Outreach work in harm reduction and the workers

HR in Bulgaria is done both by state institutions and NGOs. The main donor in the country is the Global Fund to fight AIDS, tuberculosis and malaria, funding the Program “**Prevention and control of HIV/AIDS**”.

The HR system is coordinated and controlled by two state institutions – the Ministry of Health and the National Center for Addictions, and the field work is done by over 35 NGO teams working on the following scenes: drug use, sex work, Roma populations, MSM and some prisons. There is also established a special network of 19 low-threshold centers for HIV prevention and testing on the territory of the country. Outreach workers in HR should be people with special professional training. The main characteristics are: good communication skills, problem understanding and building relationships based on trust with clients, together with efficient consulting/training of the target. These professionals are mainly social workers, psychologists, nurses with formal relevant education.



Exceptions are the para-professionals working with Roma populations who do not need a high education but must live and be part of the relevant Roma community.

The outreach work is done often as a part-time job with limited career opportunities and insufficient remuneration.

Volunteers and peer contribution is rarely used but for outreach workers these could be people chosen from some communities (Roma, MSM).



## Harm Reduction Training

The training of people who are directly involved in outreach work in harm reduction of drug abuse is regulated by the Methodical Rules of the Ordinance of Ministry of Health and is done and certified by the NCA. This training is designed as annual courses for people who are now starting HR outreach work.

The certification is obtained after 20 hours of theory, 20 hours practice in direct involvement in outreach work or drop-in centers and a successful exam pass. The theory module includes: Addiction to drugs; Health harms related to drug abuse; Strategies and interventions for the reduction of health harms; Consultation skills; Specificities of work in HR program; etc.

HR work is also part of every outreach work training done by the teams for their new members according to the specificity of work of the NGO – sex work, Roma community etc. This training is done informally with a practical focus.





“It’s really important  
to have mandatory  
harm reduction training  
for all who work in this  
area”

Outreach Worker

## CHAPTER 3

### European professional profile of the outreach worker in harm reduction

# 3. Profile construction methodology

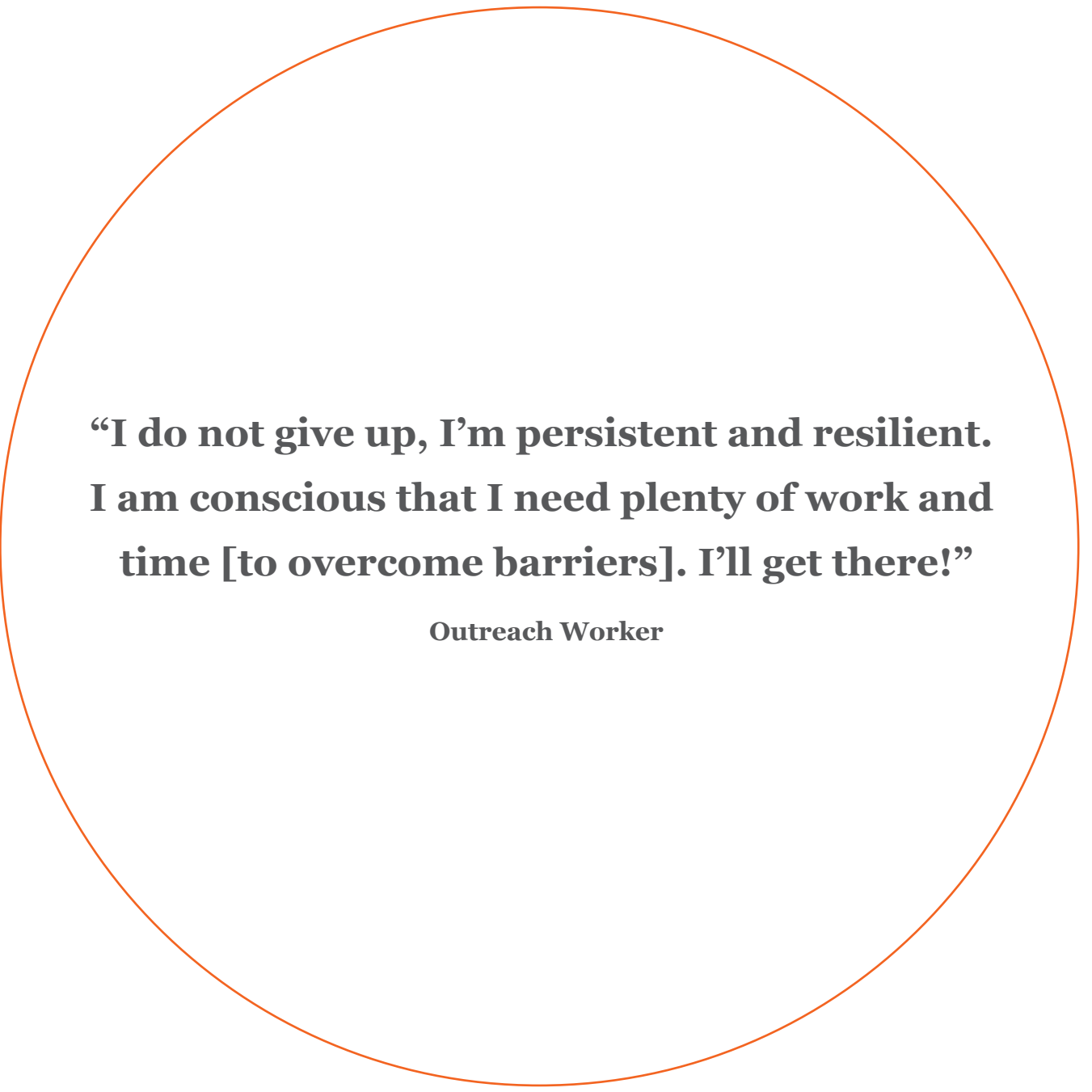
The outreach work has gained relevance in harm reduction settings and has been widely disseminated around the world. As stated in Chapter 1 - Professional recognition of the Outreach Worker in Harm Reduction – the effectiveness of outreach interventions depends greatly on the skills of the outreach worker.

Despite its relevancy and widespread dissemination, outreach work in harm reduction still lacks a framework of guidelines and working standards which can be applied at European and national levels. This leads to misinterpretations and a great arbitrariness in the understanding and development of outreach work by those involved in this area, namely organisations and their workers.

This chapter presents the methodology process for establishing the professional profile of the Outreach Worker in Harm Reduction, considering it a first step to overcoming the lack of global guidelines for working standards and the qualification of these workers.

**“If you want to test who  
will be a good policeman,  
go find out what a  
policeman does.”**

David McClelland, 1973  
American Psychological Theorist



**“I do not give up, I’m persistent and resilient.  
I am conscious that I need plenty of work and  
time [to overcome barriers]. I’ll get there!”**

**Outreach Worker**



## THE EU CONTEXT: GENERAL EMPLOYMENT AND EDUCATION POLICY

The development of the profile of the OWHR took into account the following European strategies on Employment, Education and Training:

i. **Europe 2020**. This puts forward the initiative "**Agenda for new skills and jobs**"<sup>12</sup>, which aims to include a **better match between skills and labour market needs**, bridging the gap between the worlds of Education and Work<sup>13</sup>.

i.i. **Education and Training 2020**.<sup>14</sup> Which establishes strategic objectives for **making lifelong learning and mobility a reality**, namely through increased **transparency and recognition of learning outcomes**.

Acknowledging these strategies and objectives at the level of Employment and Education Policies in the European context, the PrOWfile aimed to create a **European Standard for the OWHR Profile** matching the **competencies with the OWHR job in order to:**

### 1st

Make OWHR competencies and further qualifications transparent, understandable and fully recognized across Europe;

### 2nd

Facilitate the recognition, lifelong learning and mobility of these workers across Europe;

### 3rd

Strengthen the OWHR professional profile and identity, by improving training towards a certified qualification and official professional recognition across Europe.

12. Communication from the European Commission [2010]. EUROPE 2020: A strategy for smart, sustainable and inclusive growth. Available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:2020:FIN:EN:PDF>

13. Potters, A. and Guest, P. [2011]. Summary Report: Bridging the Skills Gap - Highlights and recommendations from the New Skills Network Seminar held in Budapest on 9-10 June 2011. Reykjavik: The New Skills Network. Available at: <http://www.newskillsnetwork.eu/doc/934>

14. Communication from the Council of the European Union [2009]. Council conclusions on a strategic framework for European cooperation in education and training ("ET 2020") [2009/C 119/02]. Available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:119:0002:0010:en:PDF>

ANFETAMINA



## THE METHODOLOGY

The OWHR profile definition is based on the job analysis methodology.

Job analysis is a systematic process for collecting and analyzing information on jobs<sup>15</sup>. Job analysis provides information about the work performed and the work environment, but it also identifies the knowledge, skills, abilities and personal competencies people need to perform their work well and to be successful<sup>16</sup>.

The job of the outreach worker in harm reduction was broken down into two components:

- The **job description** contains the activities that have to be performed, as well as information about the tools and equipment used in the job, and the working context<sup>17</sup>
- The **job specification** indicates which specific skills, attitudes, knowledge and other attributes one must have to perform the job successfully<sup>18</sup>

For the **job analysis methods**, the PrOWfile project used different methods, recognizing the importance of a multi-method approach to consider the richness of the job<sup>19</sup>. Two main steps were defined and developed:

15. Newcombe & Bywater, (2005), Guidelines for Best Practice in the Use of Job Analysis Techniques, SHL Group Plc Visser, Altink & Algera, (1997). From job analysis to work profiling Do traditional procedures still apply? in Handbook of Assessment and Selection.

16. Newcombe & Bywater (2005), Guidelines for Best Practice in the Use of Job Analysis Techniques, SHL Group Plc

17. Visser, Altink & Algera (1997). From job analysis to work profiling. Do traditional procedures still apply? in Handbook of Assessment and Selection.

18. Ibid 17

19. Ibid 16; Ibid 17

## 1 IN-COUNTRY DIAGNOSIS: AUSCULTATION OF JOB HOLDERS AND OTHER MEANINGFUL SOURCES

### Objective:

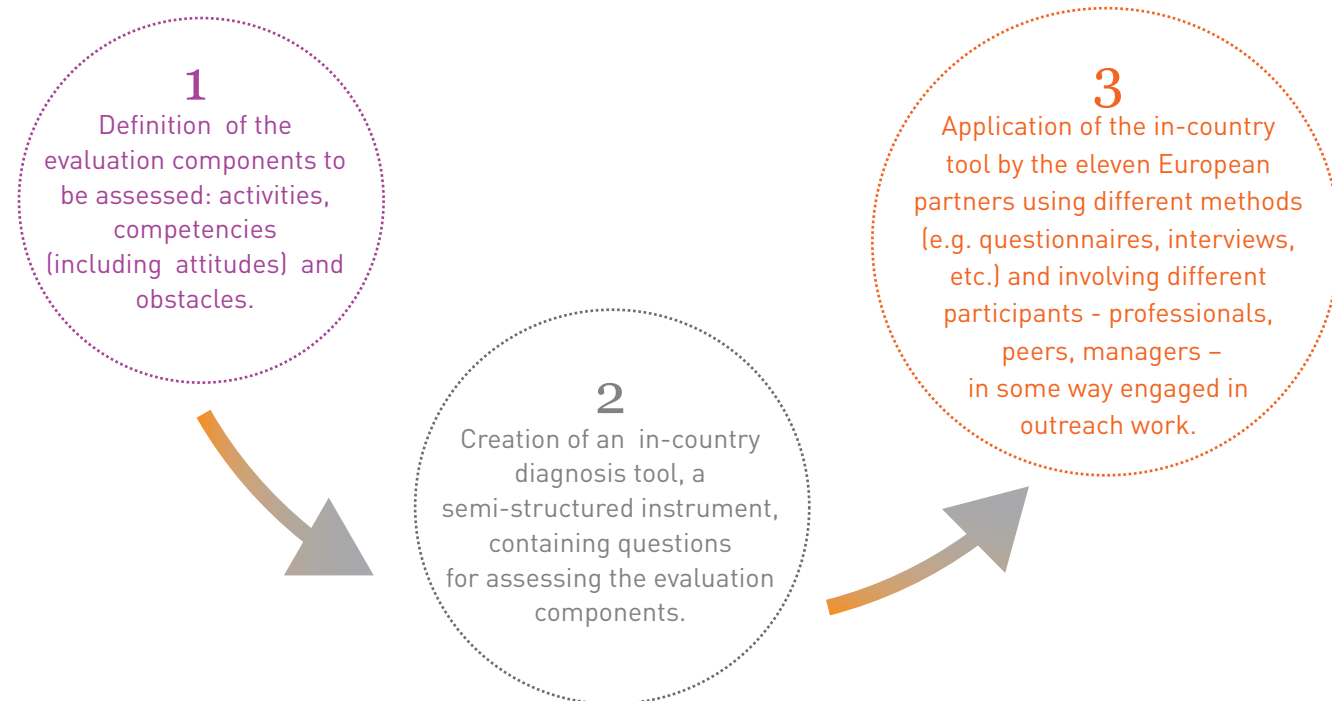
To draw up a first draft proposal of the competencies profile, containing the job description (activities) and job specification (in terms of Knowledge, Skills and Attitudes) of the outreach worker in harm reduction.

### Method:

Auscultation of job holders and other pertinent sources on the work of the outreach worker in harm reduction settings through the implementation of an in-country diagnosis process applied by the eleven PrOWfile European partners.

### Steps:

The following steps were agreed by the PrOWfile partners:



**Results:**

A draft proposal of the profile was obtained from the analysis and systematization of the data collected from 171 participants in the 11 European countries.

**In-Country Diagnosis Process Results**

Nr	Type of Participants
94	<b>Outreach Workers</b> (Professionals, Peers, Volunteers, Students)
54	Outreach Work Project Managers
23	Others (e.g. Activists, Government Workers, Policy Makers, Target Group Representatives, Researchers)

Nr	Methods
68	<b>Questionnaire</b>
30	Individual Face-to-face Interview
60	Others: Phone Interview, Focus Group, Meeting, etc.

**The data analysis of the in-country diagnosis was complemented with direct observation. The PrOWfile project visits to Outreach and Harm Reduction Services in different countries and the observation of job holders at work also provided insights for defining the OWHR profile.**

## 2 VALIDATION: STRATEGIC AND EXPERT AUSCULTATIONS

### Objective:

To validate the draft proposal of the competencies profile with the opinion of different strategic sources and experts (e.g. policy and decision-makers, researchers, networks and forum representatives).

### Method:

Implementation of meetings and focus groups in order to validate the competencies profile of the OWHR.

### Steps:

After the analysis and systematization of the in-country diagnosis, three validation steps were followed:

#### 1 Validation within the group of PrOWfile Project Partners

The draft proposal of the competencies profile was debated and reviewed amongst the PrOWfile project partners, through focus groups according to different settings of outreach work in harm reduction (Sex Work, Drug Use, Party Scenes and Prison Contexts)

#### 2 Validation by Country Experts

The reviewed profile proposal was commented on by 25 country experts from Southern Europe (Portugal), Western Europe (France), Eastern Europe (Bulgaria) and Northern Europe (Norway).

#### 3 Validation within the group of PrOWfile Project Partners

The profile proposal, now integrating comments and suggestions from various country experts, was discussed and finally validated by the PrOWfile project partners.



### Literature review of existing documentation

Existing documents were used to obtain more information about a job and to complement the construction of the competencies profile. Some examples are:

- **Good Practice in Harm Reduction** (2008). London: National Treatment Agency for Substance Misuse.
- **Outreach Competencies: Minimum Standards for Conducting Street Outreach for Hard-to-Reach Populations** (2001). The Center for HIV, Hepatitis, and Addiction Training and Technology.
- **Harm Reduction Information Kit for professionals working with at-risk populations** (2000). The Government and Public Awareness Task Group of NPNU Consortium.
- **Mobile Outreach. A guide to help plan and implement a Mobile outreach vehicle (MOV)-based risk reduction intervention program.** Center for HIV, Hepatitis, and Addiction Training and Technology of Danya International, Inc.
- **The NIDA Community-Based Outreach Model** (2000). National Institute on Drug Abuse.
- **Practical Guide to Outreach Worker and Harm Reduction with Drug Users** (2011). Association ACCES.
- **Outreach work among marginalized populations in Europe: Guidelines on providing integrated outreach services** (2007). Correlation Network – De Regenboog Group.
- **A practical manual: Working with young people at risk** (2011). Correlation Network – De Regenboog Group.
- **Practical guidelines for delivering health services to sex workers** (2008). Correlation Network – De Regenboog Group.
- **Guidelines for the evaluation of outreach work – a manual for outreach practitioners.** (2001). EMCDDA
- **Reaching drug users: A toolkit for outreach services** (2012). International HIV/AIDS.

## Results:

A professional profile of the OWHR which contemplates:

1. Activities described in terms of core and satellite tasks, by area of intervention and according to a functional sequence.
2. Competencies (designed as learning outcomes) identifying the sum of “knowledges” that are, or can be, mobilized for the development of the tasks profile. Competencies are described in terms of:

### a) Knowledges

This refers to theories and practices related to a scientific, technical or technological domain.

### b) Skills

This refers to the operationalisation of the knowledges using techniques, work methods and instruments.

### c) Attitudes

This refers to behaviours related with the action and reaction to others and the work.



*Actua  
Dona*

Programa de Información y Soporte  
para Mujeres Afectadas por el VIH/Sida



Asociació de persones  
que vivim amb VIH/SIDA

Cami 38, baixos / 08023 Barcelona  
Tel: 93 418 50 00 / Fax: 93 418 89 74  
E-mail: [actua@9cn.serviccom.es](mailto:actua@9cn.serviccom.es)  
<http://www.cambrescat.es/actua>

**“All outreach workers in general are waiting  
for a political consciousness which can value  
harm reduction projects ”**

**Outreach Project Manager**

# CHAPTER 4

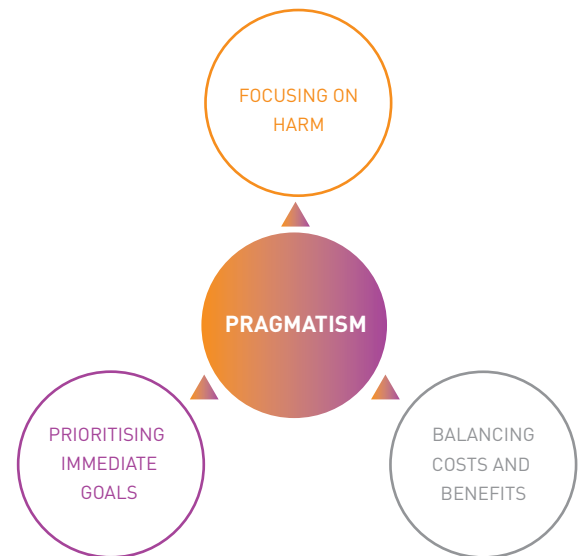
## European professional profile of the outreach worker in harm reduction

### 4.1. Principles

Harm Reduction covers interventions, programmes and policies that seek to reduce the health, social and economic harms<sup>20</sup> of primarily drug use and sex work, on individuals, communities and societies. The harm reduction approach is based on a strong commitment to public health and human rights<sup>21</sup>. There are two core HR principles from which several others can be subtracted:

#### PRAGMATISM<sup>22-23-24</sup>

Harm reduction accepts risk-taking as a common aspect of human experience. It acknowledges that, although carrying risks, drug use and sex work for example also provide benefits that must be taken into account if they are to be understood. It encourages actions towards meeting people's needs where these currently exist, and begins by promoting the minimization of related harms of the behaviour as a more pragmatic or realistic option, than the efforts to eliminate the behaviour itself.



20. Rhodes & Hedrich [2010]. Harm reduction and the mainstream. EMCDDA Ed., 2010, Harm reduction: evidence, impacts and challenges. Lisbon, Portugal: European Monitoring Centre for Drugs and Drug Addiction.

Available at: <http://www.emcdda.europa.eu/publications/monographs/harm-reduction>

21. Harm Reduction Association. What is harm reduction? A position statement from the International Harm Reduction Association. Available at: [www.ihra.net/files/2010/08/10/Briefing\\_What\\_is\\_HR\\_English.pdf](http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf)

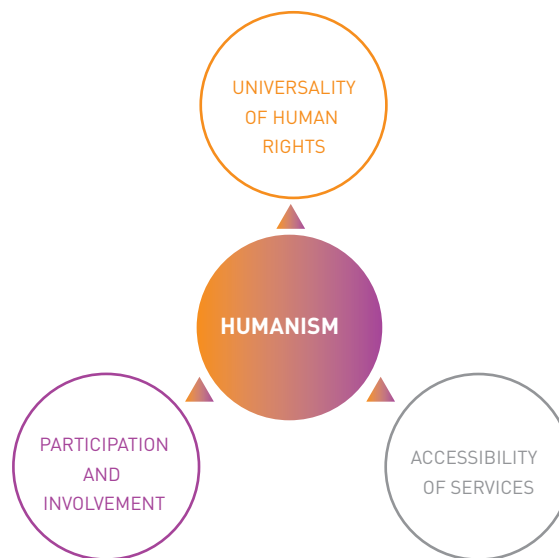
22. Manitoba Harm Reduction Network [2005]. Harm Reduction Principles and Practice. Available at: <http://www.harmreductionnetwork.mb.ca/principles.html>

23. Hunt et al. [2003]. A review of the evidence-base for harm reduction approaches to drug use. Available at: <http://www.ihra.net/files/2010/05/31/HIVTop50Documents11.pdf>

24. Ibid 21

## HUMANISM<sup>25-26</sup>

The decisions people make, for example to engage in sex work, are accepted as facts. This does not mean that one approves, but no moral judgement is made either to condemn or to support their decision e.g. in using drugs, regardless of the level of use or mode of intake. The intrinsic value, dignity and rights of the drug user, sex worker, prisoner or migrant, are respected. Harm reduction expects accessible and non-judgemental services for all and seeks to enhance social and health support programmes, while minimizing coercive measures.



Although these explanations can be readily acknowledged by outreach workers in harm reduction, the translation of the Humanism and Pragmatism principles into these workers actions requires great capacity for continuous critical thinking of their own activities and attitudes. The outreach worker deals with many unique situations, most of them with no clear and immediate solution, particularly when these circumstances require the input of principles such as Humanism and Pragmatism. It is easy to fall into and adopt inappropriate approaches when such complex situations appear:

25. Ibid 22  
26. Ibid 23



## When someone asks for support...

It might be easier to think of charity...

...instead of **empowerment!**

## When a new situation comes up...

It might be safer to keep the same limits or follow the same tracks...

...even when the situation calls for innovative (and maybe risky) and **flexible approaches!**

## When personal safety is at stake...

One may feel the need to control and eliminate the threat...

...instead of protecting the **Rights** of all (and also their own)!

What contributes to the uniqueness of harm reduction, also puts the OWHR in a situation of high uncertainty: the flexibility of the HR approach in such multifaceted, complex, diverse and sometimes illegal settings, can create difficulties for the OWHR when making decisions of what is right and wrong; what should or shouldn't be done; what makes his/her actions entirely humanistic and what doesn't; what makes his/her actions responsive instead of punitive; what makes him/her a tool of the social and public health control system and what doesn't.

To fully understand the HR principles, and for these to be part of the daily practice of the OWHR it is important to establish and incorporate such principles in the outreach worker's competencies profile and in his/her professional education and vocational training. Harm reduction education is markedly absent from professional programmes, leading to training deficiencies<sup>27</sup>. Because of these training deficiencies, outreach workers may rely on approaches that pathologize individual behaviours, ignoring the empowerment perspective of harm reduction<sup>28</sup>. Research suggests that with adequate educational and training support, outreach workers will more readily adopt harm reduction principles, embracing the pragmatism and client engagement offered by harm reduction intervention opportunities<sup>29</sup>. Continuous supervision is the best way to ensure that outreach workers keep attached to these most basic principles of harm reduction, as well as to help to maintain a critical overview of their activity. Research into the effectiveness of supervision clearly shows a positive effect on the workforce on three different levels (Paunonen-Ilmonen 2001): supervision increases work performance and quality of client based work; it enhances and clarifies workers professional identity; the organisation/team work clearly moves in a more positive direction<sup>30</sup>. Thus enhancing the individual and the team working capacity, and respect and understanding for the service users needs.

---

27. Bigler (2005). Harm Reduction as a Practice and Prevention Model for Social Work. The Journal of Baccalaureate Social Work,10(2), 69-86. Cit in Anbar et al (2012). Harm reduction policy for social work practice: Policy Considerations for the Ontario College of Social Workers and Social Service Workers. Canadian Harm Reduction Network, available at: <http://www.acch.ca/resources/Final-Policy-Brief-Social-Workers.pdf>

28. Bigler, (2005) and Hofschulte, (2012), cit in Anbar et al., (2012). 1. Harm reduction policy for social work practice: Policy Considerations for the Ontario College of Social Workers and Social Service Workers. Canadian Harm Reduction Network

29. Hofschulte, 2012 and Mancini et al., 2008, cit in Anbar et al., 2012). Harm reduction policy for social work practice: Policy Considerations for the Ontario College of Social Workers and Social Service Workers. Canadian Harm Reduction Network

30. Mikkonen, M., Kauppinen, J., Huovinen, M., Aalto, E. (2007). Outreach work among marginalized populations in Europe. Guidelines on providing integrated outreach services. Amsterdam: Foundation Regenboog AMOC. Available at: <http://www.correlation-net.org/images/stories/pdfs/products/outreach.pdf>

## 4.2. The role of the organisation

There is no doubt that outreach work is exciting and demanding. Outreach workers need to be flexible and able to relate to an ever-changing work environment. They must be ready to work with different target groups and to operate in various settings.

Outreach is crucial for many organisations that work with people in vulnerable conditions. It ensures that the target group is reached and that the organisation is accepted among community members. Outreach workers are the gatekeepers of their organisation and form the profile of the organisation towards the target group. Therefore, organisations should value and advocate for the cause that is being intervened and invest in the professional and personal development of their workers, creating a supportive working environment.

There are specific issues which should be taken into account:

### Lost in the daily practice

Practitioners, and outreach workers in particular, are often very concerned with the problems and needs of the target group. They work intensively with the group and try to find solutions for different problems. This intensive focus on individual cases means that outreach workers tend to forget the overall picture and context in which these problems occur.

### Keeping professional boundaries

Another issue for outreach workers is finding a good balance between the role of professional on the one hand, and the relationship of trust with the target group on the other. Outreach workers have to leave their comfort zone and enter the world of the target group, in which different codes, norms and values exist. This balancing act is not always easy. Sometimes, outreach workers become too much a part of the target group, unable to keep a certain professional distance.

### Working “between marginality and citizenship”<sup>31</sup>

The social and legal framework that prohibits and represses drug use and sex work, makes outreach work a risky job. The outreach worker enters ‘underground’ territories, comes into contact with unknown people, and has to deal with a certain ambiguity, “sometimes seeing themselves (and being seen) as a healthcare worker, sometimes in a condition of marginality and without warranties to perform the job”<sup>32</sup>. “For a worker who seeks that the users can “take care of themselves,” to take care of the worker himself is key”<sup>33</sup>. To promote the empowerment of users it is essential that the workers can be empowered as well, with certain job guarantees and conditions that can also be given and supported by the organisations.

### Balancing between social control and empowerment

Some authors affirm that the current policy of harm reduction is part of a social control mechanism that cares little for the user, focusing on preventing harm to their fellow citizens<sup>34</sup>. Especially in those countries where HR programmes have been implemented for many years, HR has become increasingly medicalised and professionalised. There is an increasing tendency to implement HR as a tool of social control, without making sure that the social and health benefits for drug users are guaranteed<sup>35</sup>. Keeping the balance between social control and human rights, public health and empowerment, charity and individual freedom, is a difficult task for outreach workers. Whilst acknowledging the system and the pressure towards control and discipline of social nuisance behaviours, these workers can however favour the rights of the user, actively implementing a humanist approach.<sup>36</sup>

---

31. Nardi, H. & Rigoni, R. (2005). “Marginality or citizenship? The discursive net that configures the work of outreach workers”(2005), *Psicologia em Estudo* Vol. 10, nº 2, pp. 273-282.

32. *Ibid* 31

33. *Ibid* 31

34. Quirion, B. (2002) and Fernandes, L. & Ribeiro, C. (2002) cit in “Street work with drug users: obstacles felt at the north of Portugal” (2003). Marta Pinto and Susana Peixoto. *Toxicodependências* vol. 9, nº 2, pp. 51-60.

35. Schatz, E.; Schiffer, K.; Kools, JP (2011). The dutch treatment and social support system for drug users. IDPC,

36. Pinto, M. & Peixoto, S. (2003). “Street work with drug users: obstacles felt at the north of Portugal”. *Revista Toxicodependências*, Vol. 9, nº 2, pp. 51-60.

### Being supported by the organisation<sup>37</sup>

Sometimes outreach work is not sufficiently important to the community and the organisations that promote it, thus helping to keep it underground. Some may not consider outreach and harm reduction as important pivots for the political development of the organisation. In other cases, although the importance is acknowledged, the practical investment is small (minimal resources for outreach work, selecting workers with low qualifications to perform the job, giving insufficient support to workers and project actions, not advocating for these causes). As a result outreach workers might feel isolated, similar to their target group.



Service providers should, therefore, give institutional support to workers and advocate for the rights of the target group. The protection of the institution that promotes the outreach project is essential for its effectiveness. Taking into account the difficulties faced and the fatigue imposed on workers, the organisation must provide a secure and protective structure. That is why it is desirable that the organisation is focused on outreach and these aspects, leaving the workers without the need to be unduly involved in the internal issues of the organisation<sup>38</sup>:

#### Understanding the context of outreach work and harm reduction

To avoid workers becoming 'lost in their daily work' and to understand the context in which they operate, it is important to involve them in the overall activities of the organisation. Taking into account their competencies, workers can rotate between outreach, advocacy and evaluation activities. This will help them to develop additional skills and contribute to their overall understanding of harm reduction and outreach work.

#### Providing support structures and preventing risks/harms and burnout

**Outreach work often means taking risks**, such as contracting infectious diseases and other health and security problems. Similarly, the burnout rate amongst outreach workers is high. The personal limits of outreach workers are easily challenged. It is therefore important that the organisation accepts responsibility to protect its workers and creates a stimulating, but safe working environment. This can be ensured by providing not only individual support, training, skill building and supervision, but also by developing a risk protection plan and committing to professional standards and guidelines.

---

38. Ibid 31



### Investing in the future

Creating a good and healthy working environment also means that outreach workers get the opportunity to change their work within the organisation. Organisations should invest in their workers consistently, stimulating them to develop different skills and competencies. Thus, organisations benefit from the rich experience of their workers, by valuing their knowledge and expertise and investing in their personal and professional growth.

### Promoting continuous training, skills building and supervision

Outreach workers require specific training, skills building and supervision. The fact that outreach workers operate in a non-formal setting with different codes and norms means they require specific attention. Also, populations they work with present serious problems for which most of the time there are no straightforward solutions. Mutual exchange during supervision is essential, but individual support may also be necessary. Most important is to create a safe and non-threatening working environment, in which outreach workers and peers feel free to share their questions, doubts and problems.

### The need to document and evaluate daily practice

Contributing to and promoting evidence and practice-based interventions should be an important goal for service providers active in the field of outreach and harm reduction. This means that organisations have to document and critically assess their work, evaluate interventions and adapt their approach if necessary. Continuous and systematic evaluation of interventions and activities is essential to ensure the quality and effectiveness of the work. Outreach workers should be actively involved in the evaluation of outreach and HR activities and be trained accordingly. This also gives support to outreach workers when it comes to the overall understanding of the HR field and contributes to the idea of a professional approach.

### Advocacy and networking

Promoting international relations and networking can help organisations and outreach workers in finding additional support for their harm reduction work. The impact of networking at national and international level is high and can be seen as a reinforcement of the harm reduction and outreach identity.

## 4.3. Professional Profile

The general aim of the work of the OWHR is to reduce the risks and harmful effects of drug use and sex practices of individuals/groups and the surrounding communities to promote their social, legal, health and human rights by organising, implementing and evaluating outreach strategies/services within a multidisciplinary team.

The following profile is defined as a professional profile and should be understood as a proposal of in-job working standards. It seeks to be exhaustive in terms of the activities and competencies that the outreach worker should be capable of developing. However, it is fundamental to bear in mind that this profile is not close-ended. Also it is based on the premise of a **multidisciplinary team** (nurses, medical doctors, psychologists, peers, social workers, volunteers, etc.), so it is not expected that all outreach workers should develop every activity listed below. At the same time, the extensive list of activities presented seeks to cover different areas of work, such as sex work, drug use, party and prison contexts, amongst others, and some activities may not be legal or appropriate to a country's reality, reflecting the importance of adapting the intervention to individual, cultural, social and economic backgrounds.



## ACTIVITIES

### CORE ACTIVITIES

#### 1. Contact with service users and key persons (stakeholders) in their own field



##### Good Practice Examples

- 1.1. Implement outreach strategies combining varied and timely adapted contact methods (outdoor, telephone, newspaper, internet, etc.), regarding the target populations profiles, schedules and interests
- 1.2. Provide health, social and legal support to service users, including emotional and social support, empowerment initiatives, screening and referrals according to the service users' needs and motivation
- 1.3. Register the nature of the contacts made with service users and the support activities or services provided
- 1.4. Explain and provide information to service users (and key persons) about the role and aims of the outreach work in harm reduction
- 1.5. Implement varied and appropriate intervention approaches aimed at key persons to raise their awareness on health and rights and to promote their participation/involvement in the outreach purpose

# ACTIVITIES

## CORE ACTIVITIES

---

### 2. Provide harm reduction and other **supplies** and develop health promotion



Good Practice Examples

- 2.1. Provide harm reduction supplies/equipment and other prevention paraphernalia (and encourage the return of equipment, when applicable)
- 2.2. Provide health education, adapted and updated informative materials, to raise service users' awareness on the use of harm reduction materials and other means of reducing specific harm from drug use, sex practices, tattooing, etc.
- 2.3. Deliver hygiene materials, clothes and food, when appropriate
- 2.4. Help service users to identify which risky practices they believe could be reduced or eliminated and discuss potential obstacles to promoting viable and self-motivated behaviour changes
- 2.5. Provide training to service users on harm reduction and safer practices, and promote snowballing transmission of information, namely through peer education
- 2.6. Do overdose prevention and enquire with service users on drug related deaths
- 2.7. Discuss with service users the benefits of the systematic use and exchange of preventive materials, thus promoting their autonomy and active search for these equipments



## ACTIVITIES

### CORE ACTIVITIES

### 3. Provide support services and refer service users to the local community network



#### Good Practice Examples

- 3.1. Contact, map and maintain a local community referral network
- 3.2. Undertake, when appropriate, suitable referrals and/or accompaniments to local community services (such as health, social, educational and legal services, drug treatment, social reintegration, housing, etc), according to service users' needs, and ensuring the fulfillment of their rights
- 3.3. Explain the procedures inherent to referrals and accompaniments
- 3.4. Conduct referral follow-ups, when appropriate
- 3.5. Provide outreach based services, such as emotional, legal, social, health and peer support
- 3.6. Provide leisure activities of interest for service users, when necessary
- 3.7. Collaborate on the implementation and continuation of specific outreach services, such as opioid substitution low threshold maintenance programmes, drug testing, supervised drug consumption programmes, heroin therapeutic administration and safe houses for sex workers
- 3.8. Provide adapted and updated informative materials on specific issues (e.g. migration, transgender, maternity, law, etc.) and on services available in the local community and, where relevant, in other regions or countries
- 3.9. Inform service users about professional standards, namely the obligation of the outreach worker to report, to the relevant authorities, incidents where they present a danger to themselves or others
- 3.10. Create and follow up health and individual and social integration plans, according to service users' needs (e.g. family mediation) and according to case management techniques

# ACTIVITIES

## CORE ACTIVITIES

---

### 4. Provide or refer to HIV, HCV, HBV, STI and TB prevention, screening and care; and provide general healthcare services



Good Practice Examples

- 4.1. Provide adapted and updated information on HIV, HCV, HBV, STI and TB prevention, screening and care/treatment routes, and motivate towards screening and treatment when necessary
- 4.2. Explain to service users the importance of learning about their serostatus and inform them of the behaviour changes needed to reduce transmission risks
- 4.3. Provide HIV, HBV, HCV, IST screening to clients (rapid screening tests or referral to screening services), including pre and post test counselling (and crisis intervention, when necessary)
- 4.4. Refer/accompany service users (and their sex partners, if possible) to HIV, HBV, HCV, IST and TB screening services and refer them to appropriate treatment routes, ensuring confidentiality in a secure/private environment and with psychological support and follow up
- 4.5. Encourage service users' (and their sex partners) to start and maintain HIV, HCV, HBV, IST and TB treatment, if necessary, ensuring a comprehensive, well-structured and fast referral network
- 4.6. Find mechanisms, together with the service users, to follow treatment, such as supporting them in the administration of antiretroviral and/or other therapeutic medicines (HIV post-exposure prophylaxis or TB prophylactic medication or Hepatitis B and C treatment), when necessary

## ACTIVITIES

### CORE ACTIVITIES

---

- 4.7.** Refer/accompany service users to vaccination and primary care services (e.g. for Hepatitis A and B, Tetanus, Influenza, HPV, Variola and the treatment of wounds)
- 4.8.** Refer female users for contraceptive implants and supply pregnancy tests
- 4.9.** Refer/accompany service users to specialized healthcare services, such as nutrition, gynecology, family planning and dental care
- 4.10.** Notify the relevant bodies of new HIV cases (or other public health epidemics)





## ACTIVITIES

### CORE ACTIVITIES

#### 5. Prevent or deal with emergencies and harmful situations



Good Practice Examples

- 5.1. Do an assessment of the risks/harms involved at work and in the field
- 5.2. Adopt procedures to prevent risks/harms and deal with emergencies and harmful situations (e.g. using professional identification when working in the field; using ear plugs at party scenes)
- 5.3. Protect service users by implementing risk/harm preventive strategies and deal with emergencies or specific harmful situations for the protection of the service users (e.g. provide naloxone, provide post-exposure prophylaxis, provide a relax zone or cleaning paraphernalia)
- 5.4. Provide first aid in overdose and other situations
- 5.5. Provide training to service users and caregivers, peers and volunteers in measures to reduce drug-related deaths, namely overdose training, first aid and early involvement of the emergency services
- 5.6. Adopt suitable strategies that reduce the risk of service users getting arrested or facing other negative consequences, and that prevent service providers from facing ethical and/or legal dilemmas
- 5.7. Develop and implement procedures to respond to abuses or situations of exploitation denounced by service users or observed in the field, and have clear guidelines on how to respond to field observations to avoid responses based on emotional or moral values

## ACTIVITIES

### CORE ACTIVITIES

---

#### 6. Implement empowerment actions that will increase the ability of service users to make choices and have more control over their lives



Good Practice Examples

- 6.1. Raise the service users' awareness of their human and legal rights, duties and citizenship legislation, thus developing their autonomy/empowerment and advocacy skills for their own protection
- 6.2. Support service users in their self-mobilization towards the claiming of rights, self-organization and making their causes heard
- 6.3. Provide training and involve peer workers in outreach work, facilitating their professional integration, skills development and increasing the quality of services
- 6.4. Support service users in denouncing any rights' violation and help to expedite resolutions
- 6.5. Provide training to service users and raise their awareness of general topics, such as social and health rights and negotiation skills, thus increasing their knowledge, skills and autonomy
- 6.6. Help to create and maintain peer support services/structures that advocate for the rights of the target group





## ACTIVITIES

### CORE ACTIVITIES

#### 7. Assessment of the target group and mapping the outreach setting and community services



Good Practice Examples

- 7.1. Canvassing of a target group and area, based on continued assessment and mapping, using a range of local data sources, including service users and key persons, to establish the levels of need and identify potential outreach sites
- 7.2. Register information about sites and target group dynamics, on a continuous basis
- 7.3. Maintain a local community referral network on service users' on-going needs assessment



© Stig Hauger

## ACTIVITIES

### CORE ACTIVITIES

---

#### 8. Contact and build partnerships with different stakeholders and community services to raise awareness, capacity building and social appeasement



Good Practice Examples

- 8.1. Meet with the community and key stakeholders and build relations and partnerships, involving them in the needs assessment and in the design and implementation of solutions
- 8.2. Plan, implement and evaluate actions to raise community awareness of target populations, harm reduction principles, human rights and citizenship, and its added value (economic, health and social benefits) to service users and to the general community
- 8.3. Organise and implement training sessions on the specific role of each stakeholder in respect of the needs and rights of the target group, namely to improve access to services and prompt harm reduction intervention (e.g. pharmacy staff, police, Red Cross, etc.)
- 8.4. Implement negotiation activities to promote good relations between service users and stakeholders, namely liaising with the police force and developing adequate procedures to deal with police interventions in the field
- 8.5. Provide training and raise service professionals' awareness on ethical approaches, services and procedures for service users



### 1. Project development, monitoring, evaluation and dissemination of outcomes



#### Good Practice Examples

- 1.1. Participate in the development and/or adaptation of an outreach harm reduction project plan - taking into account a previous needs assessment (the characteristics of the field and service users' needs and dynamics) - defining goals, services, activities and outcomes
- 1.2. Collaborate on the development of reports on the impact of outreach work and service users' needs for funders, policy makers, service users and other stakeholders
- 1.3. Collaborate in writing/producing papers, guides, leaflets and other support material exposing the population's needs and the impact of outreach work
- 1.4. Review, with peer workers and/or service users, materials (leaflets, guides, reports, etc) regarding service users' life and interests
- 1.5. Document, monitor, evaluate and analyse the data gathered through outreach work, in order to adapt and improve it
- 1.6. Participate in seminars, media initiatives and other events to disseminate project outcomes and to share acquired knowledge
- 1.7. Collaborate on research studies in order to increase and disseminate knowledge on the reality of the population, their needs and rights

## ACTIVITIES

### SATELLITE ACTIVITIES


---

#### 2. Implement advocacy actions to promote service users' rights and outreach harm reduction practices



Good Practice Examples

- 2.1. Raise awareness and provide training to stakeholders on service users' rights, in particular access to health, social and legal support
- 2.2. Organize and participate in collective actions and public events raising awareness of service users' rights and advocating for policy changes
- 2.3. Network with national and international organisations that support and advocate for harm reduction policies and for service users' rights
- 2.4. Negotiate with political bodies and media, promoting the outcomes of outreach work and advocating for changes in policies, legislation and practical procedures



**IF PROHIBITION COULDN'T  
CURB ALCOHOL, HOW CAN IT STOP  
SOMETHING LIKE THIS?**

Unfortunately, suppressing human desires doesn't make them go away. It just makes them go underground. Much like prohibition in the Twenties, outlawing prostitution created

a whole industry of vice, complete with disease, poverty and drugs. After two centuries of crackdowns, it's apparent that these laws aren't working. Because prostitutes still are.

**THE MARGO ST. JAMES TASK FORCE ON PROSTITUTION.**  
The more you know, the more you'll support decriminalization.

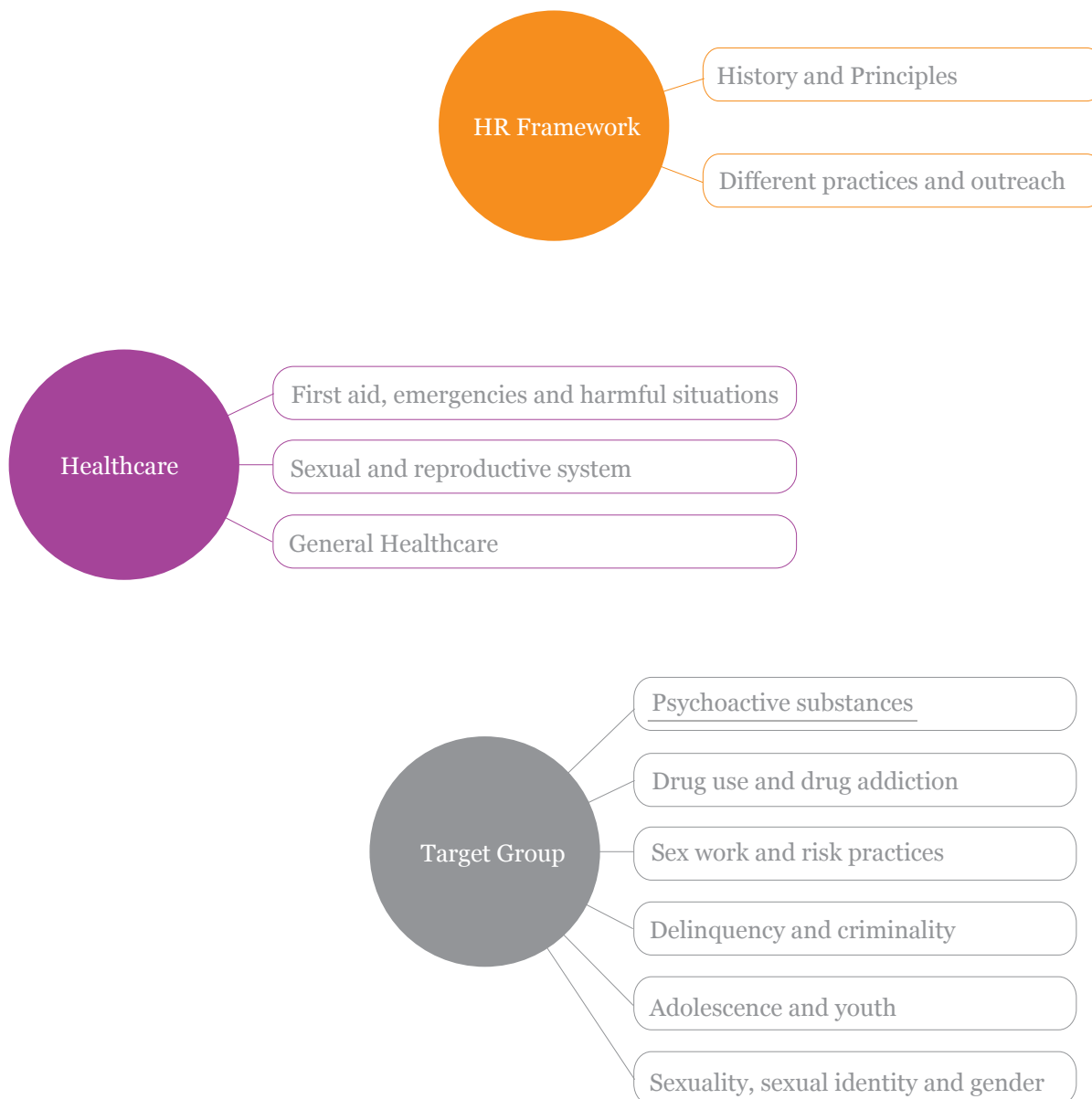
“Sometimes it is very difficult to work as an outreach worker. Especially when we have to visit any institution or state service with a client (service user). The personnel there treat us just the same way they treat our clients and transfer their negative attitude to us...”

Outreach Worker



## KNOWLEDGE

## Know to Know



# KNOWLEDGE

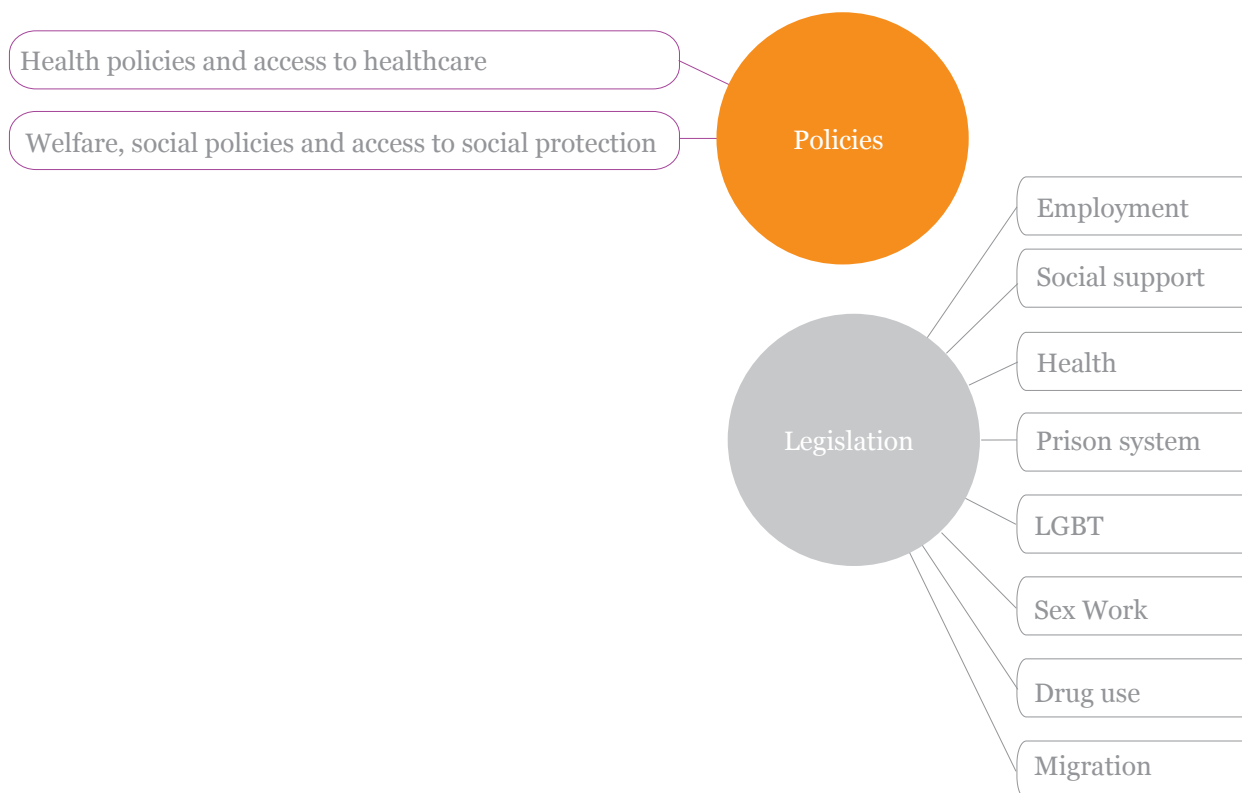
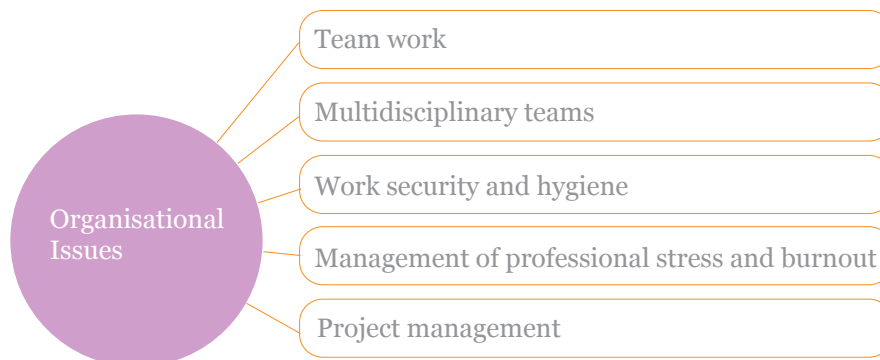
## Know to Know

---



## KNOWLEDGE

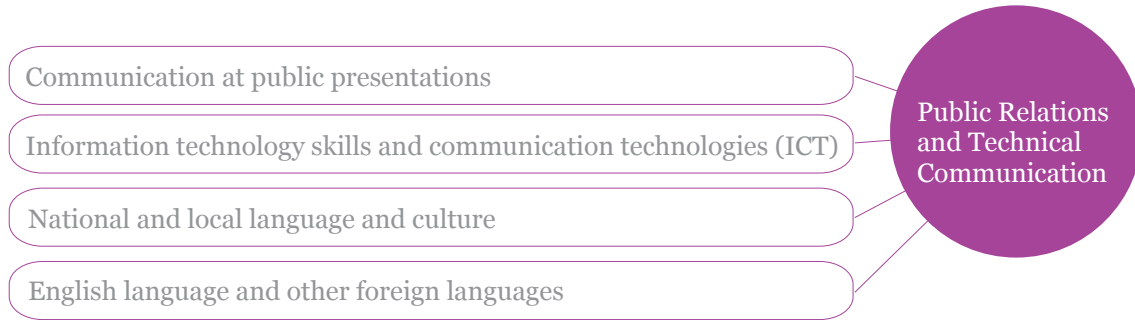
## Know to Know



# KNOWLEDGE

## Know to Know

---



“Only people who have passion for harm  
reduction, work in this field”

Researcher





## SKILLS Know How to Do

### CORE SKILLS

- Apply procedures to prevent and deal with emergencies or specific harmful situations, such as first aid techniques
- Apply conflict management and problem solving techniques with service users, when necessary
- Conduct outreach adapted to service users' characteristics and circumstances, in a variety of settings (street, community, online, indoor, etc.)
- Act respecting ethics and professional standards of the job for the protection of all involved
- Apply communication techniques, such as active listening and self-disclosure, when interacting with service users in order to establish empathic and trustful relationships
- Apply communication techniques on how to inform, using materials as resources for discussing key issues and relevant information
- Conduct motivational interviewing with service users to encourage behaviour change
- Teach service users concrete strategies and behavioural skills to reduce risk and give positive reinforcement and follow-up
- Inform service users about risk reduction issues, such as risk factors, symptoms and basic disease-related information
- Explain to service users the rules and function of local resources and services for effective referrals
- Conduct screening and pre and post test counselling
- Explain appropriate information to the service users' level of understanding level and cultural norms
- Raise service users' awareness of their rights, and advocate for them, when necessary
- Use strategies for promoting service users' empowerment and participation skills
- Promote service users motivation, autonomy and responsibility by encouraging them to access community services

## SKILLS Know How to Do

### CORE SKILLS

---

- Adapt professional conduct to the cultural background and specific characteristics of the target population acknowledging that these may influence health practices, decision making processes and outreach work itself
- Apply communication techniques and conflict management strategies when interacting with service users with aggressive behaviour, mental health problems or under the effects of drugs
- Carry out crisis intervention procedures
- Provide humanistic emotional support techniques, such as empathic understanding
- Provide an anonymous and secure environment, allowing service users to talk about their life and needs, in accordance with legal and ethical limits of confidentiality
- Communicate in the national language, in English or other language, in order to reach national, migrant and foreign target populations
- Master informal communication and discussion group techniques
- Undertake referrals, providing immediate and responsive access to services
- Collect information on how local resources and services work and the rules for establishing referrals
- Collect relevant data, namely on service users, outreach settings and activities
- Explain to service users the outreach worker's role and the type of support provided
- Master observation techniques in field research
- Inform about rules, obligations and professional boundaries
- Work as a team to maximize credibility and the safety of all parties involved (outreach workers, service users, community, etc)
- Apply case management strategies within a multidisciplinary team and with the community services

**SKILLS** Know How to Do**CORE SKILLS**

---

- Maintain confidentiality when sharing information between organisations and in public or semi-public encounters
- Define outreach activities and services according to the needs assessment
- Establish and maintain a referral network according to service users' needs
- Provide training and integrate peers, volunteers and co-workers in the field work
- Plan and implement systematic outreach and follow-up work
- Manage time effectively

## SKILLS Know How to Do

### SATELLITE SKILLS

---

- Involve stakeholders, working in partnership, to develop appropriate harm reduction strategies and outreach programmes
- Conduct group meetings with different stakeholders, to share knowledge and to raise their awareness of the target groups' needs and rights
- Liaise with the media to transmit the service users' needs and outreach activities and outcomes
- Liaise and cooperate with law enforcement to implement and monitor changes resulting from harm reduction policies
- Advocate with key stakeholders and decision makers for the promotion of policy changes that respect service users' rights
- Document and analyse services provided to the service users, and characteristics of outreach sites
- Use evaluation instruments within the outreach worker's scope of practice
- Produce and document evidence to support experimental initiatives
- Write reports, papers and other documents on outreach activities and the target groups' needs, providing evidence of effectiveness

“To what extent do you manage a balance  
between what is ethical and what is legal?”

Outreach Worker

# ACID

UN FILM DI  
**GIUSEPPE  
SCOTTESE**

delirio dei sensi







“Harm reduction is characterized by its ethical principles, as well as by the posture and competencies of the workers who develop it.”

Outreach Worker

## ATTITUDES Know How to Be

### CORE ATTITUDES

---

- Be committed to outreach and harm reduction ideology and people's Human Rights
- Demonstrate a pragmatic and enduring attitude
- Recognize service users' knowledge, experience and determination to make choices
- Respect the service users' decisions, privacy and circumstances in order to establish relationships of trust
- Value the strengths and limitations of the service user
- Treat service users with dignity and sensitivity
- Respect service users' cultural background, values and personal characteristics, such as ethnicity, gender and sexual orientation
- Show understanding of the variance in cultural beliefs and values that may influence health practices and decision making processes and affect responsiveness to different outreach strategies
- Maintain non-judgemental and non-coercive behaviour, avoiding critical, condescending and paternalistic attitudes
- Do not impose any standards, values or beliefs upon service users nor encourage any particular course of action
- Act based on experimented technical and/or scientific approaches to avoid charity responses
- Accept social diversity as part of society
- Act based on a holistic vision and multidisciplinary responses
- Establish horizontal and proximity relationships with service users

## ATTITUDES Know How to Be

### CORE ATTITUDES

---

- Be genuine, without pretense, role-playing or defensiveness
- Be able to recognize, build and maintain adequate personal and professional limits
- Be assertive, congruent and communicate clearly
- Manage realistic expectations about the support that can be provided
- Build empathic and trustworthy relations with service users and stakeholders
- Be persistent, resilient and tolerant to frustration when interacting with service users and stakeholders
- Be accessible, demonstrating interest and availability when interacting with service users
- Be patient and supportive with service users
- Be able to adapt to different and adverse environments, particularly in the field where the target groups are
- Be capable of adapting to different outreach approaches/methods/settings
- Work autonomously (or with supervision) and in a multidisciplinary team, with peers and volunteers
- Be able to motivate service users
- Reinforce service users' positive identity
- Encourage and give responsibility to target groups
- Keep a balance between public health and human rights approaches
- Demonstrate emotional stability and self-control, especially in critical situations
- Ask for team or organisation support structures, when necessary
- Demonstrate self-assurance, confidence and self-determination

## ATTITUDES Know How to Be

### CORE ATTITUDES

---

- Demonstrate observation skills and accurate record keeping
- Demonstrate leadership skills in order to establish professional limits and rules
- Keep an attitude of continuous improvement and motivation
- Demonstrate capacity to deal with the lack of resources and professional limitations resulting from policy and legal frameworks
- Demonstrate critical thinking
- Be committed and aware of the professional role of the outreach worker
- Demonstrate the ability to reflect on the outreach worker's role within a multidisciplinary community of workers
- Be cooperative, acting as a link between the field/target group and community services
- Act in a manner that protects service users' interests and rights
- Be prepared to work outside of a plan
- Be flexible and open-minded
- Demonstrate pro-activeness and creativity in dealing with circumstances and obstacles
- Demonstrate positive curiosity and engagement
- Act regarding territory knowledge and dynamics
- Show understanding of the target groups' life context and economic, social and health situation
- Reject stigma, discrimination, violence and social injustices towards the target group
- Acknowledge the need for self-protection by assessing risks
- Seek to improve the lives of target groups and communities

## ATTITUDES Know How to Be

### CORE ATTITUDES

---

- Seek equal opportunities for target groups
- Be able to cope with stress
- Be capable of handling with bureaucracy
- Deal with issues without taboos, and with humour when appropriate
- Promote choice and always act with the service users' consent
- Be prepared for rejection from people in the target group
- Maintain a balance between field work and other follow-up work
- Engage with service users, respecting their privacy and motivations
- Identify and respect the target groups' characteristics, needs, interests and motivations



## ATTITUDES Know How to Be

### SATELLITE ATTITUDES

---

- Be committed to research and use of evidence-based practice
- Be open to sharing key experiences, knowledge and concerns with other outreach workers and peers through networking actions
- Use dialogic and assertive negotiating/advocating skills with stakeholders



**Piercing?**

**Tattoo?**

**Aber sicher:**

beim Profi und mit sauberem Gerät

Gebrauchte Nadeln können HIV und Hepatitis übertragen –  
nicht nur beim Drogenkonsum

# CONCLUSION

---

## **European professional profile of the outreach worker in harm reduction**

The main objective for developing a professional profile for the outreach worker in harm reduction was to make clear that those delivering outreach in HR settings are extremely skilled workers. Therefore, much should be done to improve their training and employment conditions, in order to strengthen the results of their interventions and their impact in the communities they work with.

Harm reduction is endorsed as a valuable approach by many European countries, but, despite this, little has been invested in those who develop and implement it in the field. Outreach workers in harm reduction settings are frequently undervalued or underestimated by their professional colleagues in their line of work. Reinforcing the identity of the OWHR and strengthening their professional capacity should be a priority. Without the recognition of standards, such as a professional profile and a vocational education and training programme, harm reduction services will simply be less effective.

The acknowledgement of this professional activity goes hand in hand with an increased awareness of a professional working class. This cannot be handled from an individual perspective. The proposal of a profile contributes to strengthening the workers as a professional class, promoting a stronger sense of their role within their organisation, and more broadly in the health and social systems.

It is our understanding that the professional career should be one of the main concerns in the recognition of OWHR. Advocating for a career is creating the conditions for a route that the worker can follow during his/her working life. We live in a labour market where discontinuity and instability are becoming more and more structural, and fighting for a career can help to ensure both employment stability and continuity of services, in place of fragmented responses that depend on unpredictable funding. A career linked to a strong professional identity empowers the worker and activates his/her political participation, claiming his/her voice in the design of policy regarding their area of work and the rights of all involved, namely the target groups.

Acknowledging the political, cultural and social differences amongst European countries and the various contexts of implementation of the outreach work in harm reduction, the profile published here is an extensive and exhaustive proposal, but not final. We are by no means closed to a comprehensive definition of this profile, considering the different actors who carry out this job, namely the Peer and the Volunteer. The diversity of backgrounds, experiences and skills of those involved makes a single and linear definition of the outreach worker profile much more complex and challenging.

This proposal will most certainly be enriched over time but we believe that at least a starting point has been created for a wider debate on the professional recognition of the OWHR.

# LIKE AN ORGY,

IT ONLY WORKS IF THERE'S A LOT OF US.



**EXOTIC  
DANCERS  
ALLIANCE**

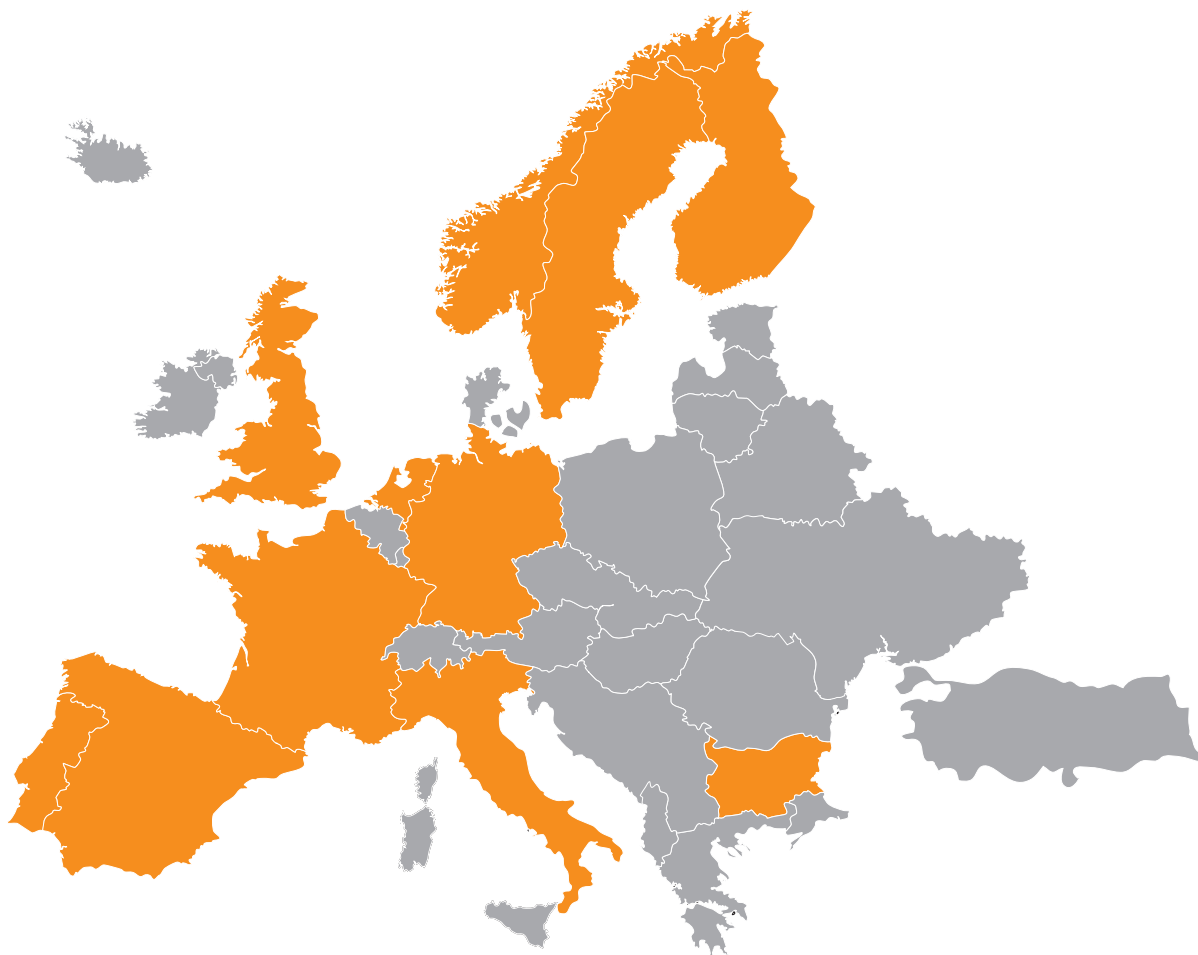
2215-F market st, suite 108  
sf, ca 94114 tel: 415.995.4745  
www.eda-sf.org

“[to overcome obstacles from institutions is important]  
To avoid “iron arms” with these organisations  
and always focus on the target group needs.”

Outreach Worker

# Partners

European professional profile of the outreach worker in harm reduction





## APDES



PORTUGAL



**APDES** is an NGO, founded in 2004 with the main aim of promoting integrated development.

APDES works with vulnerable people and communities in domains such as access to healthcare, employment and education, seeking to empower these populations and reinforce social cohesion. Its core principles are: Human Rights protection, action research and evaluation methodologies, participative and proximity models of intervention; empowerment and citizenship; activism and policy action; transdisciplinary approaches.

Therefore APDES's profile is oriented to:

- (a) providing proximal intervention services to vulnerable people and communities in national and international contexts;
- (b) producing critical understanding and research on the health and social reality;
- c) advocating for fair health and social policies.



SPAIN



## ABD

**ABD** - Asociación Bienestar y Desarrollo is a NGO declared of public utility. ABD activity is focused on prevention, treatment, insertion, mediation and research on AIDS, drugs addiction, domestic/gender violence, family and children at risk, healthcare attention, justice and intercultural fields. These activities are done by involving not only the group but also the community. The main goal is to eradicate inequalities and social exclusion by promoting public participation, which means collaborating with other organisations, promoting voluntary work, cementing a human group and a social network which generates civic values, such as solidarity and justice.

ABD is formed of more than 1000 professionals and 400 volunteers, working in Spain on more than 50 different projects. It is present in Catalonia, Madrid, Andalucía and the Balears Islands and has also participated in two European projects in 2011.

## A-Clinic Foundation

The **A-Clinic Foundation** operates through its regional units to reduce alcohol, drug and other addiction problems by providing versatile professional services. The Foundation provides treatment, detoxification and rehabilitation services in order to improve the quality of life for people with addiction problems and their families.

The A-Clinic Foundation is an active participant in international activities within the EU and in neighbouring previous Soviet countries. The Foundation is active in projects and networks involving substance abuse education, utilizing new information techniques, drug use prevention and harm reduction, child protection, poverty, and marginalisation.

The A-Clinic Foundation was founded in 1955. The Foundation has over 700 employees and an annual budget of about 45,9 million euros. The services are funded mainly through contracts with municipalities. Project funders include Finland's Slot Machine Association, the Ministry of Social Affairs and Health, the Finnish Centre for Health Promotion and the European Union.



FINLAND



**A-klinikkasäätiö**



## THE NETHERLANDS



## FOUNDATION THE RAINBOW GROUP

**Foundation The Rainbow Group** (FRG) is an Amsterdam-based NGO committed to people with social problems, such as homelessness, drug and alcohol abuse and psychiatric disorders. The organisation provides low-threshold health and social services, such as day centres and night shelters, psychosocial support, drug consumption rooms and needle exchange programmes. Furthermore, FRG provides social support through buddy projects.

## HARM REDUCTION INTERNATIONAL

**Harm Reduction International** is a leading non-governmental organisation working to promote and expand support for harm reduction. With over 8,000 members worldwide, Harm Reduction International is the largest membership-based global harm reduction association. We work to reduce the negative health, social and human rights impacts of drug use and drug policy – such as the increased vulnerability to HIV and hepatitis infection among people who inject drugs – by promoting evidence-based public health policies and practices, and human rights based approaches to drug policy. HRI is an influential global source of research, policy/legal analysis and advocacy on drug use, health and human rights issues.



UNITED KINGDOM



**HARM  
REDUCTION  
INTERNATIONAL**



GERMANY



## AKZEPT

**Akzept** is a federal association for acceptance orientated drug work and humane drug policies, founded in 1990. It is the national harm reduction umbrella organisation in Germany. With about 50 organisations of drug counselling services, 120 individual members (staff of drug counselling services, doctors, scientists, lawyers, police and self-help associations (users and parents of users).

Akzept arose as a countermovement against the repressive drug policies of the late 80s when ideas of harm reduction were widely rejected and the abstinence approach was predominant in drug services and policies.

The intention of Akzept was (and still is) to develop and implement measures of harm reduction in order to i) improve of the health of drug users and ii) to change the view of general society.

Keywords for the demands and efforts of Akzept are: a) Integration of the views and expertise of users; b) Prevention by means of substitution treatment, needle exchange, consumption rooms and access to treatment of co-infections (HIV/HCV).

Overall Akzept aims to decriminalize possession and use of drugs which means a legal controlled trade for individual use (by adults). Akzept pursues this policy through different activities.

## HESED

**HESED** (Health and Social Development Foundation) was founded in 1998 as a successor to the first organisation working in the field of HIV/AIDS prevention in Bulgaria. The organisation's mission is to create opportunities for personal and community development, health and social well-being, to develop and promote effective approaches for successful integration of disadvantaged communities.

The Foundation has established and maintains services in 3 main areas: health and support programmes for vulnerable groups; Roma community development; behavioural change research. In the course of 15 years HESED's team has participated in the development, implementation, monitoring and evaluation of complex national and international projects in the field of health promotion, harm reduction and STI/HIV/AIDS prevention targeted at sex workers, Roma population, (injecting) drug users and men who have sex with men.



BULGARIA







ITALY



## ITACA

**Itaca** is a long-standing organization at European level. It was founded in 1992.

Itaca associates professionals working in the field of drugs as preventive action, treatment, harm reduction and research. Its associates come from different countries, professional profiles and work approaches. Its main mission is to foster open-minded collaboration and debate between people from different national and professional backgrounds in order to develop common strategies, techniques and good practice which are evidence based and protect human rights. Itaca, along its life, has been partner in several European Projects of research and networking. Itaca organizes conferences, working groups, meetings and training courses.

Actually, Itaca is active through its European Office in Roma and National Delegations in Italy, Spain and Greece. Itaca is member of European Civil Society Forum from the beginning.

## AFR



FRANCE

Created in 1998, the **French Harm Reduction Association** (AFR – Association Française de Réduction des risques) is the French national umbrella gathering both individuals and NGOs working in the harm reduction field with the aims of:

- Advocating for public health and human rights oriented drug policies;
- Developing practice sharing between members and other concerned stakeholders.

AFR promotes drug user participation and respect of their life choices.

AFR supports its members in their development by organising practice sharing, training sessions, thematic seminars, etc. In the last years, they have focused mainly on the integration of the French harm reduction services into the new national regulation in this field.

Every 2 years, AFR organises the National Harm Reduction Meeting which gathers around 500 stakeholders. The last National Harm Reduction Meeting took place in Paris in October.



Réduisons les risques  
liés à l'usage de drogues



NORWAY



**UTESEKSJONEN**  
 HJELP NÅR DU TRENGER DET  
 TELEFON 913 03 913

## UTESEKSJONEN

**Uteleksjonen** undertakes street-based outreach social-work services aimed at children and young people at risk, and provides outreach health and social services for adults with substance-abuse problems.

Their main service is carried out using outreach patrols (always in pairs of two outreach workers) daytime to midnight throughout the year. They attempt to establish contact with individuals whom they feel are in danger of developing, or who have developed, problems associated with drugs and crime.

Uteleksjonen and its patrols in the city centre are operational on weekdays from 8am – 12pm, Saturdays from 10am – 12pm and Sundays from 4pm – 12pm. At weekends they also have patrols until 4am in the morning.

The Counselling Service is open on weekdays from 10am – 3pm. Target group, service users and collaborating partners can visit Uteleksjonen with or without appointments, for a conversation or meetings, and for counseling and collaboration.

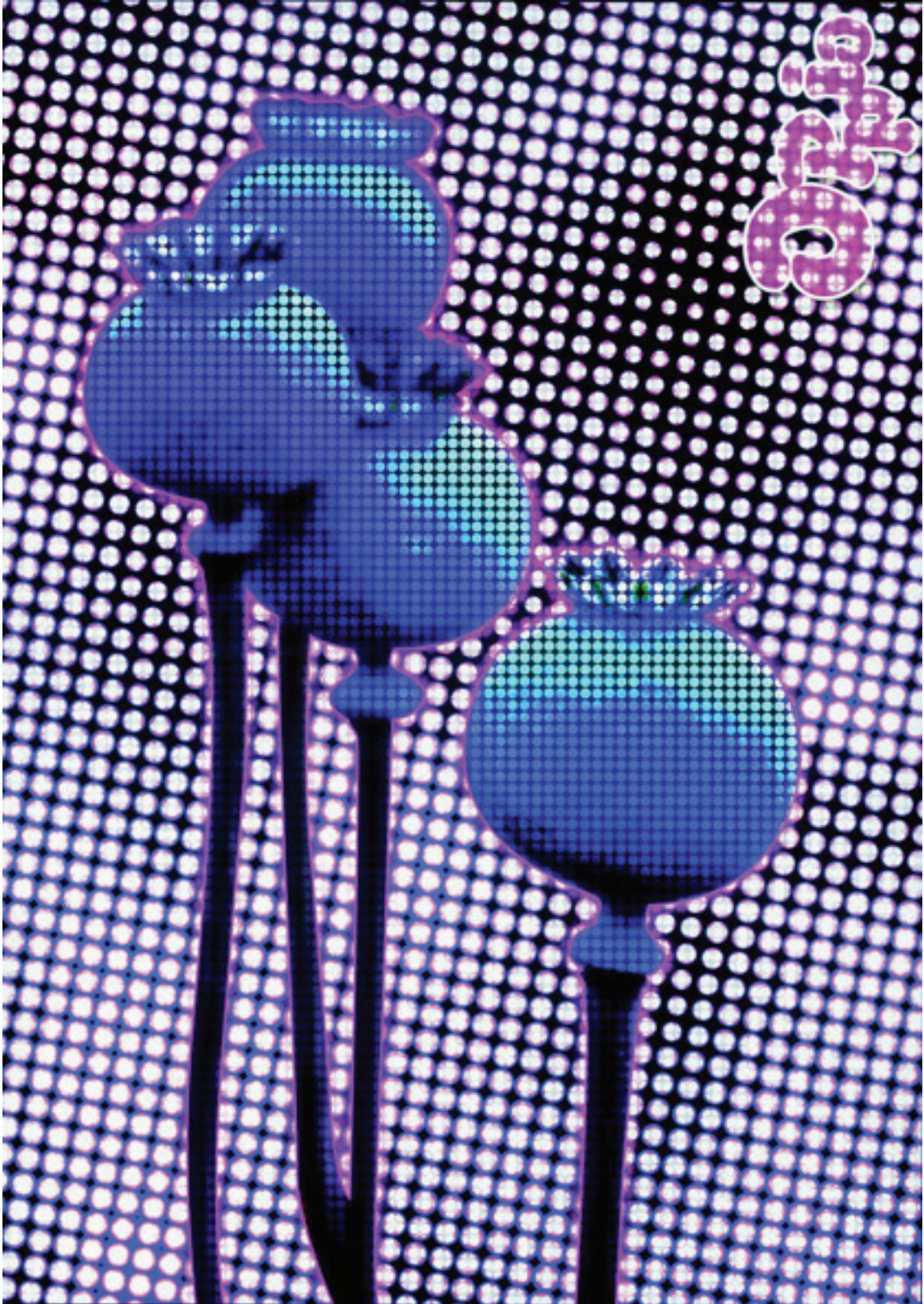
## ROSE ALLIANCE

**Rose Alliance** is an organisation for current and former sex workers in Sweden. Rose Alliance's main activities are advocacy on policies and practices, networking with other community based organisations, and peer support and peer education with a focus on health, safety and rights. Rose Alliance also provides workshops for empowering and internal strengthening of its members, as well as external lectures for, and collaboration with service providers, policy makers and other stakeholders. In partnership with HIV-Sweden, the organisation is currently doing a project on methodology for peer to peer HIV-prevention for sex workers. All those involved in the project are peers, from the project manager to the outreach worker. Rose Alliance is a member of NSWP (Network of Sex Work Projects), ICRSE (International Committee on the Rights of Sex Workers in Europe) and EuroHRN.



SWEDEN





“It looks to me that politicians see harm reduction as a means of social control. They don’t value the fact that drug use is a right, and that it doesn’t mean that people lose their other rights as a citizen.”

Outreach Project Manager




# ABBREVIATIONS

---

## European professional profile of the outreach worker in harm reduction

GO	Governmental organisation
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HR	Harm reduction
MSM	Men who have sex with men
NGO	Non-governmental organisation
OW	Outreach Worker
OWHR	Outreach Worker in Harm Reduction
PLHIV	People living with human immunodeficiency virus
STI	Sexually transmitted infection
TB	Tuberculosis





# SSS

Solo Sesso Sicuro, ecco il senso di questa sigla che forse qualcuno già conosce. Soprattutto ora che è divenuta tristemente nota un'altra sigla: AIDS. Ma, in realtà, è facile evitare il contagio se si pratica Solo Sesso Sicuro. L'importante è seguire alcune elementari precauzioni: ridurre il numero dei partner ed usare sempre il preservativo. NON AVER DUBBI DI SAGGIARSI LA VITA.



COMMISSIONE NAZIONALE PER LA LUTTA CONTRO L'AIDS  
*Ministero della Sanità*

# GLOSSARY

---

## European professional profile of the outreach worker in harm reduction

This glossary, while not exhaustive, is designed to provide readers with definitions or explanations of some of the terms that appear in the document, providing some additional references on how the terms are to be understood in this context.

**Action Research** is a participatory methodology which seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of concern to people, and more generally the enhancement of individuals and communities, through the promotion of their autonomy.<sup>1</sup>

**Advocacy** is about working towards achieving a change regarding policies, rights, guidelines or practice. It is often done targeting specific stakeholders in order to work towards a desired change.

**Antiretroviral medicines** are used in the treatment of people infected with a human immunodeficiency virus (HIV). The standard treatment consists of a combination of drugs (often called “highly active antiretroviral therapy” or HAART) that suppress HIV replication.<sup>2</sup>

**Burnout** is physical or emotional exhaustion, especially as a result of long-term stress or dissipation.

**Community** is used to describe a group of people that have something in common. It can be anything from a common practice or behaviour, cultural and geographical context, sexual identity, economic activity or ethnic background. When discussing a community it is important to recognize the diversity of people’s experiences.

---

1. Reason and Bradbury (2001). Handbook of Action Research: Participative Inquiry and Practice. Sage Publications Ltd.

2. [www.who.int](http://www.who.int)

**Competence** is the ability to apply learning outcomes adequately in a defined context, for example at work<sup>3</sup>. Includes the use of cognitive competence - theory and experience knowledge; functional competence – skills; personal competence - personal and professional values and ethics applied to conduct.<sup>4</sup>

**Crisis intervention process** is short term and should solve an emergency problem and the main goal is to help the client return at least to the pre-crisis situation. Can be divided into several steps: assessment - identify and understand the problem; planning - think of different solutions for the problem and devise an action plan; implementation - implement problem solving strategies. Crisis situations can be of various scopes: physical, psychological, social, economical, etc.

**Diversity** is often used to acknowledge that people have many different characteristics, experiences and backgrounds even if they have something in common. Recognizing a wide variety of experiences is important in order not to stereotype people and increase social stigma, regarding for example individual's sexual orientation, gender, socioeconomic status, ethnicity and culture.

**Empowerment** is about encouraging the sense, knowledge and skills, in respect of civil, legal and human rights in order to achieve an individual and/or collective strengthening.

**Hard to reach communities or populations** is an expression used to describe groups that are hard to access by service providers, such as outreach workers. Very often service providers find people who are “hidden” to be harder to reach than people in the street scene for example. In order to provide services to these groups, community key persons might be an important source of information and a potential access.

---

3. CEDEFOP (2008). Terminology of Education and Training Policy. A selection of 100 Key Terms. Luxembourg: Office for Official Publications of the European Communities, 2008. Available at: [http://www.cedefop.europa.eu/en/Files/4064\\_EN.PDF](http://www.cedefop.europa.eu/en/Files/4064_EN.PDF)

4. Commission of the European Communities (2005). Commission Staff Working Document Towards a European Qualifications Framework for Lifelong Learning. Brussels: Available at: [http://ec.europa.eu/education/policies/2010/doc/consultation\\_eqf\\_en.pdf](http://ec.europa.eu/education/policies/2010/doc/consultation_eqf_en.pdf)

**Harm reduction** is related to policies, programmes and aims to prevent or reduce negative health consequences associated with certain behaviours, such as unsafe drug use practices, unsafe sex practices or unsafe tattooing. In relation to drug injecting, “harm reduction” components of comprehensive interventions aim to prevent transmission of HIV and other infections that occur through sharing of non-sterile injection equipment and drug preparations.<sup>5</sup>

**Harm reduction supplies** is any equipment used or delivered when providing services in harm reduction settings. Their main goal is to promote safer practices, such as using a condom.

**Key persons** are important contacts in the community (for more institutional contacts see stakeholders). If services are provided to people who use drugs, key persons might be dealers. If services are targeting sex workers important contacts might include clients or brothel owners. Key persons can also belong to the community who access services, people who live in the area or run a business and who cater to the target group, like bars and shops.

**Key populations** is used to describe communities most affected by a certain issue. For example: people who use drugs, sex workers and MSM are considered to be key populations in HIV-prevention.

**Learning outcome** is the result of a specific qualification. It is what a person actually knows and is able to do, being defined in terms of knowledge, skills and competences.<sup>6</sup>

**Low threshold** is a concept that indicates an easy access to services with few demands/rules in place for service users, designed specifically for people with a history of relapses and with difficulties accessing the formal service network.

5. [www.who.int](http://www.who.int)

6. EC Education and Culture. The European Qualifications framework for lifelong learning. Available at: [http://ec.europa.eu/education/pub/pdf/general/eqf/leaflet\\_en.pdf](http://ec.europa.eu/education/pub/pdf/general/eqf/leaflet_en.pdf)

**Multidisciplinary team** is a term used to describe a variety of different interprofessional working dynamics within a working team. Working in a multidisciplinary team requires many skills, which involves understanding not only one's own role but also the role of other professionals.

**Naloxone** is a type of medicine called an opioid antagonist. It blocks the actions of opioid medicines such as heroin, morphine, (diamorphine, codeine, pethidine, dextropropoxyphene) and methadone. It is an evidence-based method for managing drug overdose.<sup>7</sup>

**Networking** is a supportive system of sharing information and services among individuals, groups or organisations, which have a common practice or are linked by a common interest of achieving a particular goal.

**Outreach** is a client-oriented working method based within the community and target groups' own environment or territory. It is an important approach for hard to reach communities or populations to provide them with a variety of health and social services in their own settings without the need for them to enter static services. Outreach is not a single activity and it can be described as a group of activities, which includes different models of establishing contact and intervention. In Europe the outreach activities have different descriptions, such as street work, street social work, field work, etc.<sup>8</sup>

---

7. [www.eurohrn.eu](http://www.eurohrn.eu)

8. Svensson, Njål Petter og Tommy Huseby (2003). Outreach work with young people: Young drug users and young people at risk. Available at: <https://wcd.coe.int/ViewDoc.jsp?id=1302697&Site=COE>

**Outreach worker** in harm reduction is used to describe a worker who develops his/her core activities in outreach and harm reduction settings, being detached from the organisation's office.

It can be either a professional (eg. nurse, psychologist, social worker, etc.), who has been trained in a particular area of intervention (drug use, MSM, sex work, PLHIV, steroid users, transgender people, ethnic minorities and people who are homeless) or a person with life experience in these particular areas who has been trained in peer education, HIV and other infectious diseases prevention and harm reduction. These peers bring life experience and trained professionals bring technical expertise, for example, in counseling, treatment, care, rights and laws, health education and other issues. They may also act as advocates for the target population.<sup>9</sup> In this context, for the purposes of this professional profile, and the E-Book, the definition of the outreach worker is: “Frontline Harm Reduction Worker in outreach settings paid or unpaid” (e.g. volunteers, peers, professionals, students). This definition includes such diverse outreach settings as party scenes, drug use settings, sex work and prison contexts.

**Overdose** is the use of any drugs in such an amount that acute adverse physical or mental effects are produced. Overdose may produce transient or lasting effects, or death. The lethal dose of a particular drug varies with the individual and with circumstances.<sup>10</sup>

**Peer led/driven activities** refers to activities either started by, or with an involvement of people that have a similar experience as the target group.

**Peer education** is a method of providing information and knowledge and promoting skills by peers in order to empower people linked to them by similar experiences in their own community. Peer education is often seen to be the most effective way to distribute information widely, including to hard to reach communities.

9. International HIV/AIDS Alliance available at: <http://www.aidsalliance.org/publicationsdetails.aspx?id=90629>

10. [www.idpc.net](http://www.idpc.net)

**Post-exposure prophylaxis** (PEP) is a short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure.<sup>11</sup>

**Psychoactive substances** are substances that, when taken in or administered into one's system, affect mental processes, e.g. cognition or affect. This term and its equivalent, psychotropic drugs, are the most neutral and descriptive terms for the whole class of substances, licit and illicit, of interest to drug policy. 'Psychoactive' does not necessarily imply dependence-producing, and in common parlance, the term is often left unstated, as in 'drug use' or 'substance abuse'.<sup>12</sup>

**Qualification**, in terms of job requirements, is "the knowledge, attitudes and skills required to perform the specific tasks attached to a particular work position".<sup>13</sup>

**Risk pattern** is a recurrent way of acting by an individual or group towards a given object or situation, that makes him, or them, face the possibility of suffering a harm or loss.

**Serostatus** is the state of either having or not having detectable antibodies against a specific antigen, as measured by a blood test (serologic test). For example, HIV seropositive means that a person has detectable antibodies to HIV; seronegative means that a person does not have detectable HIV antibodies.<sup>14</sup>

**Service user** is defined in this context as meaning any person who uses harm reduction services provided by service providers. Sometimes service users are referred to as visitors, participants, clients or patients. Service users can belong to many different communities, for example people who use drugs, MSM, sex workers, PLHIV, steroid users, transgender people, ethnic minorities and people who are homeless.

---

11. [www.who.int](http://www.who.int)

12. [www.who.int](http://www.who.int)

13. CEDEFOP, 2009, European Guidelines for validating non-formal and informal learning. Available at: [www.cedefop.europa.eu/en/Files/4054\\_EN.PDF](http://www.cedefop.europa.eu/en/Files/4054_EN.PDF)

14. AIDS info available at: <http://aidsinfo.nih.gov/>



**Sex worker** is a person, of any gender, who exchanges sexual services for money or other forms of payment. Sexual services can be physical, visual or audial. Sex work can occur in a variety of arenas as well as in a formal or informal setting.

**Social stigma** is a concept used to describe prejudice and exclusion from society based on a preconception, a stereotype, of someone that belongs to a marginalized community.

**Stakeholders** are groups in society who have an interest or obligation, a stake, to work or report on issues regarding services, guidelines or policies. Example of stakeholders: Local government, health and social services, police, media, universities, pharmacies, NGOs, business companies and cultural organizations. Stakeholders are often targeted by those doing advocacy work.

**Target group** is a community identified as a group in need of services (see service users and hard to reach communities or populations).

**Transgender people** is not a homogeneous concept, it depends on the national definition and also on the personal definition (transgender, transvestite, transsexual...). Transgender persons may wish to change their legal, social, and physical status – or parts thereof - to correspond with their gender identity. It may include modification of bodily appearance or function by dress, medical, surgical or other means as part of the personal experience of gender by transgender people.<sup>15</sup>

---

15. Commissioner for Human Rights, 2009 available at: <https://wcd.coe.int/com.intranet.InstraServlet?Index=no&command=com.intranet.CmdBlobGet&IntranetImage=1824655&SecMode=1&DocId=1433126&Usage=2>

**prOwfile**  
European Profile  
of the  
Outreach Worker  
on Harm Reduction

PrOwfile project funded by:



E-Book edited by:

